Montana Strategic Suicide Prevention Plan

MONTANA
Department of Public Health & Human Services

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SUICIDE PREVENTION IN MONTANA:

A WORK IN PROGRESS

Introduction

Suicide persists as a major public health problem in Montana. There are many individuals and organizations working to address this issue. The individuals and agencies currently addressing suicide often do so from their own unique perspective and in many cases without collaboration with other entities. Until 2000, there had been no statewide, strategic effort to link these many assets and to build a stronger network of resources to address suicide as a major statewide public health priority.

In the spring of 2000, the Montana Department of Public Health and Human Services invited a group of private organizations, concerned citizens and government officials to begin the development of a statewide plan for suicide prevention. With consultation from international experts in suicide prevention, the Montana Suicide Prevention Steering Committee began work that led to the development of this statewide strategic plan. This document is a continuation of the initial planning effort, which originally outlined a 5-year strategic direction and an action plan.

This plan was updated in the spring of 2005 and again in the summer of 2008 by key stakeholders committed to reducing suicide in Montana. Accomplishments and ongoing challenges are delineated. Strategic directions for prevention, intervention, postvention and coordination among providers are expanded, along with special attention to groups within Montana's population with the highest risk of suicide.

Progress

Since 2007, there have been significant accomplishments made toward addressing the issue of suicide in the state of Montana. Some of the primary accomplishments are included below. A complete description of the current suicide prevention activities going on at the state, local, and tribal level can be found in Appendix A.

Some of the primary suicide prevention accomplishments include:

- Creation of a state-wide Suicide Prevention Coordinator through the Department of Public Health and Human Services. This position will coordinate all suicide prevention activities in the state, conduct statewide public awareness campaigns, and provide resources to schools, law enforcement, military personnel, social service providers, tribal and local communities.
- Stabilization of the Montana Suicide Prevention Crisis line. The crisis line has two regional call centers with increased staff, updated computers, updated phone lines, and updated databases.
- The Montana National Guard formed a Post Deployment Health Reassessment (PDHRA) Task Force to evaluate and confirm the adequacy of our redeployment processes and improve access to mental health services for veterans. Some of the programs include the development of crisis response teams, suicide prevention and PTSD training, expanded family resource centers, and easier access to the VA system.
- State-wide media campaign improving suicide prevention awareness in the public. This includes television and radio ads seen throughout the state.
- Evidenced-based suicide prevention curriculum being made available to every high school in the state. The SOS (Signs of Suicide) program is being implemented in schools throughout the state.

Challenges

Though we have made progress since the initiation of the inaugural Suicide Prevention Plan, Montanans are still faced with many challenges. Montana's suicide rate remains among the highest in the Nation. Over the past seven years, suicide is the second leading cause of death for children, adolescents and young adults in our state and the rate of suicide is high throughout the life span. We have identified many areas where improvements can be made.

Lack of statewide coordination

- Systems collaboration between tribal entities, counties and state government, especially for adolescent and young adult populations are insufficient.

- Coordination between community levels and state systems is insufficient. Local communities may not know about initiatives in other parts of the state or in state government. State government agencies are often not aware of prevention efforts related to suicide in other agencies.

- Development of suicide prevention strategies often occurs without the involvement of youth in the planning process.

- Screening for mental illness and suicide does not consistently occur in public schools, juvenile justice systems, or other child-serving agencies. Screening is inconsistent in the medical community and symptoms of depression are often missed by medical professionals.

Montana demographics and geography

- Montana is a large frontier state with many isolated communities.
- There is a generational culture of acceptance of suicide as a viable option to resolve feelings of hopelessness and when one feels they are a burden to others.
- Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment.
- According to the Census Bureau, in 2007, 16.1% of the population or 154,000 Montanans, lacked health insurance coverage (Missoulian, 9/05/08).
- Montana has a high availability of lethal means, especially firearms, that increase the lethality of impulsive suicidal behaviors .
- Montana has high rates of alcoholism and other drug addictions; including the current devastating epidemic of Methamphetamine use.
- The farm and ranch economic crisis and the difficulty in attracting industry to provide a stable employment market in Montana are ongoing stressors.

Lack of mental health providers and treatment facilities

- There is a shortage of inpatient mental health treatment facilities. The availability of this vital resource is diminishing with the closure of inpatient psychiatric beds.
- The funding/reimbursement for outpatient services throughout the state is considered inadequate by many providers.
- There is insufficient integration of traditional and culturally specific interventions.
- Montana has a severe shortage of psychiatrists, especially child and adolescent psychiatrists.
- Montana has a shortage of psychiatric mental health nurse practitioners.
- Montana does not recognize Licensed Marriage and Family Therapists (LMFT) as a separate professional license. This further reduces mental health resources in the state. There are only two states in the nation that do not recognize LMFT's, Montana and West Virginia.
- There is a shortage of physicians capable of providing appropriate psychiatric medication treatments.
- There is a shortage of postvention services available to schools and communities concerning how they react after a suicide has occurred.

Suicide – The Magnitude of the Problem

United States

Overall, suicide rates have remained fairly stable over the last 20 years. However, increases in the rates of suicide among certain age, gender, and ethnic groups have changed. Suicide rates among adolescents and youth in some areas of the nation have increased dramatically. At the other end of the age spectrum, suicide rates remain the highest among white males over the age of 65. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

Approximately 700,000 people a year in the United States require emergency room treatment as a result of a suicide attempt. Suicide has a devastating and, often lasting, impact on those that have lost a loved one as a result of suicide. While suicide rates in the U.S. place it near the mean for industrialized nations, the rates within the U.S. are highly variable by region and state. The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently at the top of the rate chart annually. The following information was taken from the Center for Disease Control (2008):

In 2005:

- Suicide was the eleventh leading cause of death for all ages.
- Suicides accounted for 1.4% of all deaths in the U.S.
- More than 32,000 suicides occurred in the U.S. This is the equivalent of 89 suicides per day; one suicide every 16 minutes or 11.05 suicides per 100,000 population.
- The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states: 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines.

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 78.8% of all U.S. suicides.
- During their lifetime, women attempt suicide about two to three times as often as men.
- Suicide is the eighth leading cause of death for males and the sixteenth leading cause for females.
- Among males, adults ages 75 years and older have the highest rate of suicide (rate 37.4 per 100,000 population).
- Among females, those in their 40s and 50s have the highest rate of suicide (rate 8.0 per 100,000 population).
- Firearms are the most commonly used method of suicide among males (56.8%).
- Poisoning is the most common method of suicide for females (37.8%).

2000 - 2005, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Cumulative Population	Age-Adjusted Rate
188,187	1,735,715,405	10.77

Nonfatal Suicidal Thoughts and Behavior

- Among young adults ages 15 to 24 years old, there is 1 suicide for every 100-200 attempts.
- Among the general population, there is 1 suicide for every 25 attempts.
- Among adults ages 65 years and older, there is 1 suicide for every 4 suicide attempts.
- In 2005, 16.9% of U.S. high school students reported that they had seriously considered attempting suicide during the 12 months preceding the survey. More than 8% of students reported that they had actually attempted suicide one or more times during the same period.

Racial and Ethnic Disparities

- Among American Indians/Alaska Natives ages 15- to 34-years, suicide is the second leading cause of death.
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (21.4 per 100,000) are 1.9 times higher than the national average for that age group (11.5 per 100,000).
- Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (14.9%) than their White, non-Hispanic (9.3%) or Black, non-Hispanic (9.8%) counterparts.

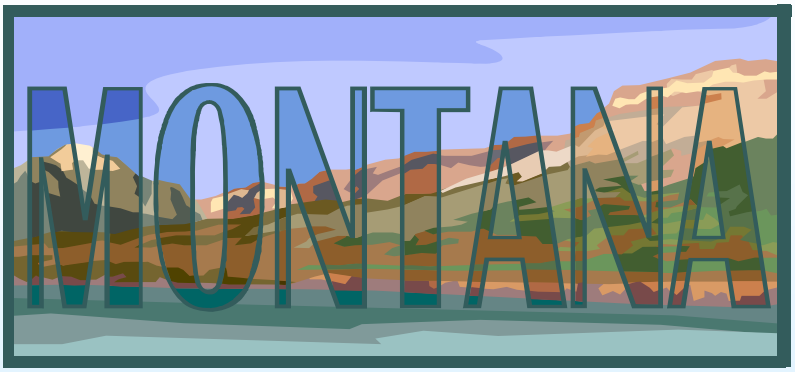
Nonfatal, Self-Inflicted Injuries

- In 2005, 372,722 people were treated in emergency departments for self-inflicted injuries.
- In 2005, 154,598 people were hospitalized due to self-inflicted injury.

Suicide-Related Behaviors among U.S. High School Students

In 2005:

- 16.9% of students, grade 9-12, seriously considered suicide in the previous 12 months (21.8% of females and 12.0% of males).
- 8.4% of students reported making at least one suicide attempt in the previous 12 months (10.8% of females and 6.0% of males).
- 2.3% of students reported making at least one suicide attempt in the previous 12 months that required medical attention (2.9% of females and 1.8% of males).



Suicide continues to be a major public health issue in the state. Montana has been at or near the top in the nation for the rate of suicide for nearly three decades. In the past seven years, the rate of suicide in Montana is 19.50 per 100,000 people (the national average has been around 11 per 100,000). Since 2000, 1,087 Montana residents have completed suicide for an average of 180 people per year.

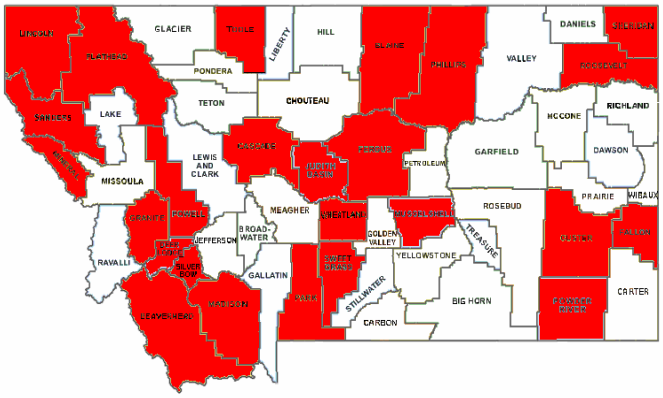
- For all age groups for data collected for the year 2005, **Montana is ranked number one in rate of suicide in the United States** (Kung, et al, 2008) and Montana has been in the **top five** for the past **thirty years**.
- Between 2000 and 2005, suicide was the number **two** cause of death for children **ages 10-14**, adolescents **ages 15-24,** and adults **ages 25-34**, behind only unintentional injuries (CDC, 2008)
- **Alcohol** and **drug impairment**, a sense of **hopelessness**, underlying **mental illness**, and a **societal stigma against depression**, all contribute to the high rate of youth suicide in Montana.
- In 2005, **25.6% of high school students in Montana** reported they felt so **sad or hopeless almost every day for two weeks or more** that they stopped doing some of their usual activities (Montana YRBS, 2007).
- Between 2000 and 2005, the highest rate of suicide in Montana was among **American Indians** (21.47 per 100,000) followed by Caucasians (19.33 per 100,000).
- **Firearms** (66%), hanging (13%), and drugs (10%) are the most common means of suicide in Montana.

2000 - 2006, Montana
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, All Ages
ICD-10 Codes: X60-X84, Y87.0,*U03

Number of Deaths	Cumulative Population	Age-Adjusted Rate
1,258	6,442,943	19.50

Suicide in Montana Counties

The suicide rate in Montana's counties varies from year to year due to small populations in the rural counties that greatly influence the rate of suicide with even one completed suicide. However, over the past seven years, 45% of Montana's counties presented with a suicide rate at or above the 80th percentile when compared to national numbers. During this seven year period, 21 Montana counties had a rate of suicide that was double the national average (Montana Vital Statistics, 2008).



2000-2006 Rate of Suicide for Montana Counties (per 100,000 people)

Counties in Red indicate a Suicide Rate at or above the 80th Percentile Nationally

County	# of Suicides	Rate	County	# of Suicides	Rate
BEAVERHEAD	17	27.2	MADISON	15	30.4
BIG HORN	13	14.4	MEAGHER	2	14.6
BLAINE	12	25.4	MINERAL	7	25.6
BROADWATER	5	16	MISSOULA	122	17.7
CARBON	11	16.1	MUSSELSHELL	9	28.6
CARTER	1	10.7	PARK	30	27.1
CASCADE	123	22	PETROLEUM	0	0
CHOUTEAU	5	12.7	PHILLIPS	6	20
CUSTER	24	30.1	PONDERA	8	18.4
DANIELS	2	15	POWDER RIVER	3	23.9
DAWSON	10	16.3	POWELL	10	20.4
DEER LODGE	20	31.5	PRAIRIE	0	0
FALLON	5	26	RAVALLI	51	18.9
FERGUS	17	20.8	RICHLAND	11	16.9
FLATHEAD	124	22.3	ROOSEVELT	16	21.7
GALLATIN	88	17	ROSEBUD	8	12.3
GARFIELD	0	0	SANDERS	23	30.8
GLACIER	18	19.3	SHERIDAN	6	23
GOLDEN VALLEY	0	0	SILVER BOW	56	24
GRANITE	4	19.8	STILLWATER	9	15.3
HILL	16	13.9	SWEET GRASS	6	23.4
JEFFERSON	12	16.1	TETON	4	9.1
JUDITH BASIN	4	25.7	TOOLE	8	21.7
LAKE	37	19.2	TREASURE	0	0
LEWIS & CLARK	73	18.2	VALLEY	9	17.6
LIBERTY	0	0	WHEATLAND	5	34
LINCOLN	29	21.9	WIBAUX	0	0
MCCONE	2	15.6	YELLOWSTONE	161	17.2

Gender

Montana is consistent with the rest of the U.S. in that suicide deaths vary by gender with males at greater risk than females. During the period from 2000 through 2005, Montana males were almost five times more likely than females to complete suicide (CDC, 2008). There were 891 completed suicides by males in Montana and 187 completed suicides by females during that period. More females choose *reversible* means such as poison; more males choose *irreversible* means such as fire arms. Figure 1 shows the percentage of completed suicides by gender for the period between 2000 and 2005.

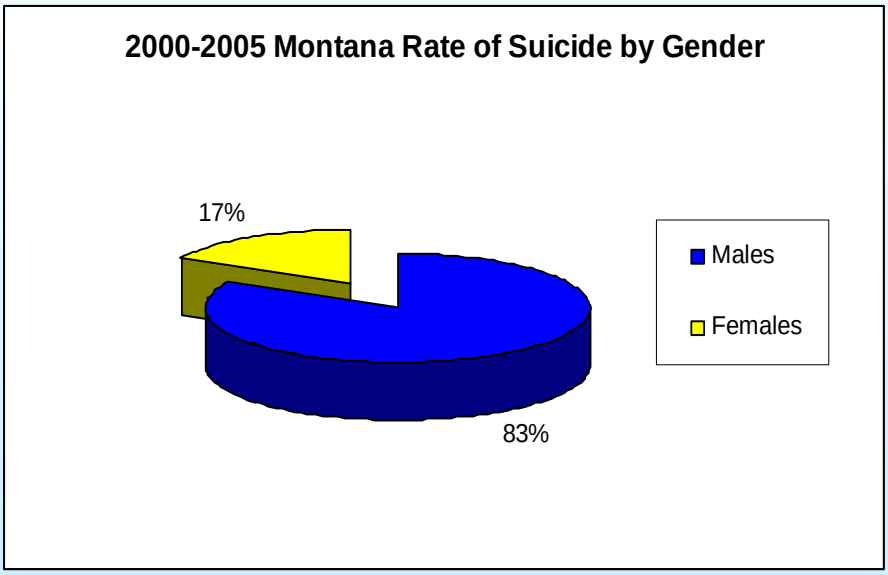


Figure 1

Race

Suicide in Montana also varies, to some degree, by race. The small population of American Indians and African American residents in Montana results in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year. Taking into account this rate variability due to small populations, the difference in rates between American Indians, African Americans, and Caucasians in Montana is minimal when considered over time. All the rates are much too high. Figure 2 documents the similarities in rates by race between the years 2000 and 2005 (CDC WISQARS, 2008).

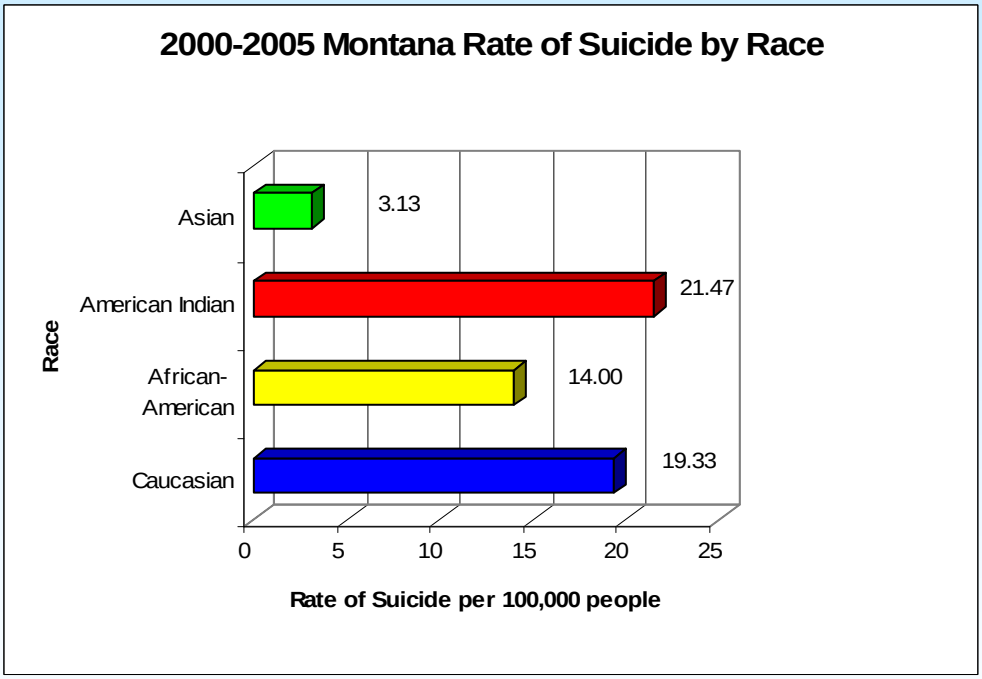


Figure 2

While Figure 2 does not break down the American Indian population into the various subdivisions of nations, tribes, bands and clans, for any given time period there is a high degree of variability among these classifications, just as there is similar variability among the Caucasian population when stratified by counties, cities and towns. What is clear from Figure 2 is that it is important to track the rates of suicide over time since any one year period may demonstrate marked deviation from the mean.

Specific risk factors for American Indian communities contribute to the suicide rates for this population. These include high unemployment rates, alienation and varying cultural views on suicide.

For African-Americans, the year to year variability is even greater. During the years between 2000 and 2005, there were four completed suicides by African-Americans. However, the rate of suicide in Montana for African-Americans is 14.0 *per 100,000*.

Age

When all ages are combined, suicide is ranked the 9th leading cause of death for Montanans. However, when those rankings are examined by age group, the risk of suicide for Montanans over the past six years is a prominent public health issue from adolescents through the life span. Between 2000 and 2005, there were 14 suicides by Montanans ages 10 to 14, 153 suicides between the ages 15 to 24, 177 between the ages 25 to 34, 223 for ages 35 to 44, 201 for ages 45 to 54, 126 for ages 55 to 64, and 184 for ages 65 and over (CDC WISQARS, 2008). For all of these age groups, the rate of suicide was near or double the national rate. Figure 3 documents the rate of suicide for different age ranges in Montana between 2000 and 2005.

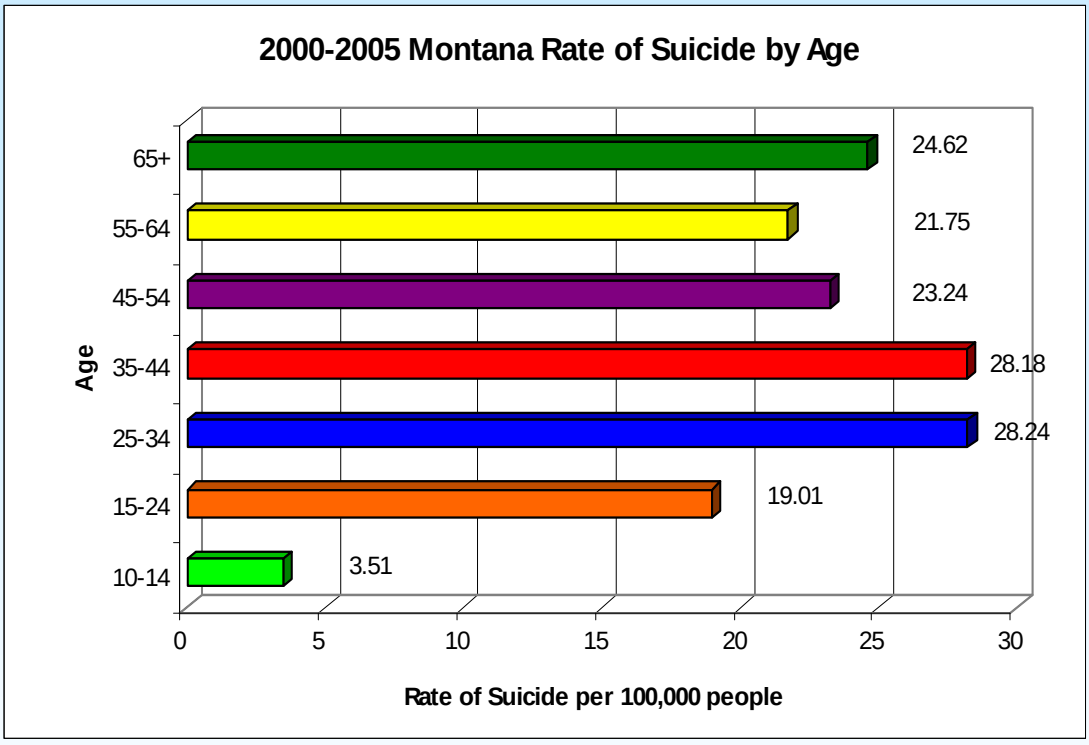


Figure 3

Lethal Means

A number of means are used in the act of suicide in Montana. Of these, firearms is the most common means of completing suicide accounting for 715 of the 1,078 suicides between 2000 and 2005, followed by poisoning (181) and suffocation (152). Other lethal means include: drowning (10), cutting/piercing (5), jumping from heights (3), fire/burn (3), motor vehicle (1), etc. There were 8 completed suicides where the mean was not identified or unspecified. Figure 4 verifies the preponderance of firearms in Montana suicides.

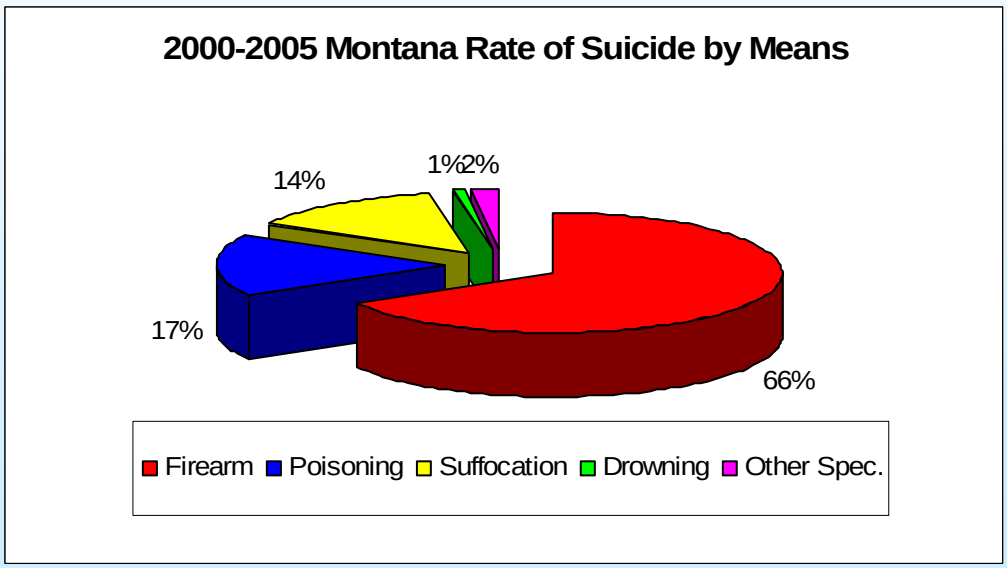


Figure 4

Cost of Suicide in Montana

Nationwide, suicide attempts and deaths by suicide ripple through the U.S. economy, costing up to $1.9 billion for inpatient hospitalization alone and $25 billion per year in direct and indirect costs (Litts, et al., 2008).

For all ages between 1999 and 2003, the Suicide Prevention Resource Center (2008) estimated that the average medical cost of a **completed suicide** in Montana was **$2,941** while the average work-loss cost per case was **$980,957.**

In Montana, there were an average annual total of **904 hospitalized suicide attempts per year** (106 per 100,000 people). For all ages between 1999 and 2003, the average medical cost of a **hospitalized suicide attempt** was **$8,939** while the average work-loss cost per case was **$8,082** (Children's Safety Network Economics & Data Analysis Resource Center, 2008).

Completed Suicides

Average Cost Per Case

Age Group	Medical	Work-Loss
5-14	$3,512	$1,407,300
15-19	$1,973	$1,495,148
20-29	$3,792	$1,584,046
30-49	$2,617	$1,239,900
50-69	$2,765	$578,695
70+	$3,515	$80,500

If you include medical costs ($468,900), quality of life costs ($300,184,300), and work-loss costs ($161,186,800), **Montanans lose approximately $461,837,000 (based on the 2004 dollar) per year on completed suicides** (Children's Safety Network Economics & Data Analysis Resource Center, 2008)**.**

Estimated Hospitalized Attempts

Average Cost Per Case

Age Group	Medical	Work-Loss
5-14	$7,007	$14,069
15-19	$6,384	$7,771
20-29	$8,645	$13,211
30-49	$9,412	$10,118
50-69	$12,175	$6,984

Montana Youth Risk Behavior Survey – Montana Youth and Suicide

The Montana Youth Risk Behavior Survey is administered by the Montana Office of Public Instruction every two years to 7th and 8th grade students and to high school students. The purpose of the survey is to help monitor the prevalence of behaviors that not only influence youth health, but also put youth at risk for the most significant health and social problems that can occur during adolescence. There is some variation in the questions asked every two years. In 2005 there was a focus on Montana youth and suicide.

In the 12 months prior to taking the 2005 YRBS, 15 percent of 7th and 8th grade students and 18 percent of high school students reported considering suicide. Twelve percent of 7th and 8th grade students and ten percent of high school students reported actually attempting suicide in this same time period. Results of the investigation indicate the following (for complete results and data, go to http://opi.mt.gov/YRBS/):

- Montana youth who have attempted suicide are more likely to have used/abused alcohol than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to have smoked or used chewing tobacco than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to have used methamphetamines than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to have used marijuana than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to have, in their lifetimes, sniffed glue or used inhalants to get high than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to be sexually active than youth who have not attempted suicide.
- Montana youth who have attempted suicide are more likely to have been in at least one fight in the 12 months prior to taking the survey than youth who have not attempted suicide.
- Montana youth who have not attempted suicide are more likely to think of themselves as being at “about the right weight” than youth who have attempted suicide.

The 2007 YRBS provided specific data concerning trends over time and with special populations as it pertains to suicidal behavior in Montana's youth:

2007 Youth Risk Behavior Survey
Montana High School
Trend Report

Injury and Violence	1995	1997	1999	2001	2003	2005	2007
Percentage of students who . . .							
Felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities during the past 12 months			**25.9**	**26.6**	**26.4**	**25.6**	**25.8**
Seriously considered attempting suicide during the past 12 months	**21.8**	**23.9**	**18.6**	**19.4**	**18.9**	**17.5**	**15.1**
Made a plan about how they would attempt suicide during the past 12 months	**19.2**	**18.7**	**15.6**	**16.3**	**14.8**	**14.6**	**13.2**
Actually attempted suicide during the past 12 months	**8.5**	**8.4**	**6.7**	**10.4**	**9.7**	**10.3**	**7.9**
Had a suicide attempt resulting in injury, poisoning, or overdose that required medical treatment during the past 12 months	**2.8**	**2.4**	**2.5**	**3.7**	**3.0**	**3.1**	**2.7**

2007 Youth Risk Behavior Survey
Montana Comparative Report
American Indian students on Reservations (AI-Res)
American Indian students in Urban Schools (AI-Urban)
Alternative Schools (Alt School)
Students with Disabilities (SWD)

Injury and Violence	High School	AI –Res	AI – Urban	Alt School	SWD
Percentage of students who . . .					
Felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	**25.8**	**32.8**	**35.6**	**39.2**	**36.8**
Seriously considered attempting suicide during the past 12 months	**15.1**	**18.1**	**24.3**	**26.2**	**23.6**
Made a plan about how they would attempt suicide during the past 12 months	**13.2**	**17.6**	**19.5**	**20.2**	**21.1**
Actually attempted suicide during the past 12 months	**7.9**	**15.8**	**18.4**	**16.0**	**17.7**
Had a suicide attempt resulting in injury, poisoning, or overdose that required medical treatment during the past 12 months	**2.7**	**4.9**	**4.7**	**5.8**	**5.3**

Risk and Protective Factors associated with Suicide

Risk Factors

Risk factors are long standing conditions, stressful events, or situations that may increase the likelihood of a suicide attempt or death. The following lists are representative of information found in suicide literature. While no list is all-inclusive, those included below serve to summarize an enormous amount of information.

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Risk factors do not cause suicide, but when many factors are present, these may increase an individual's vulnerability. The following risk factors for all ages are identified in the National Strategy of Suicide Prevention (2001):

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

When the risk factors for specific age groups are explored, some differences are evident. The following are the risk factors identified for youth and the elderly:

Risk Factors for the Young (The risk factors were taken from the Maine Youth Suicide Prevention Program, 2006, created through the Maine Department of Health and Human Services and by the Montana Strategic Suicide Prevention Plan Work Group, 2008)

Family Risk Factors

- Family history of suicide (especially a parent)
- Changes in family structure through death, divorce, re-marriage, etc.
- Family involvement in alcoholism
- Lack of strong bonding/attachment within the family, withdrawal of support
- Unrealistic parental expectations
- Violent, destructive parent-child interactions
- Inconsistent, unpredictable parental behavior
- Depressed, suicidal parents
- Physical, emotional, or sexual abuse

Environmental Risk Factors

- Access to lethal means
- Frequent mobility
- Religious conflicts
- Social isolation/alienation or turmoil
- Exposure to a suicide of a peer
- Anniversary of someone else's suicide
- Incarceration/loss of freedom
- High levels of stress; pressure to succeed
- Over-exposure to violence in mass media

Behavioral Risk Factors

- One or more prior suicide attempt(s)
- Alcohol/drug abuse
- Aggression/rage/defiance
- Running away
- School failure, truancy
- Fascination with death, violence, Satanism

Personal Risk Factors

- Mental illness/psychiatric conditions such as Depression, Bipolar, Conduct and Anxiety disorders
- Poor impulse control
- Confusion/conflict about sexual identity
- Loss of significant relationships
- Compulsive, extreme perfectionism
- Lack skills to manage decision-making, conflict, anger, problem solving, distress, etc.
- Loss (or perceived loss) of identity, status
- Feeling powerless, hopeless, helpless
- Victim of sexual abuse
- Pregnancy or fear of pregnancy
- Fear of humiliation

Risk Factors for the Elderly (taken from Luoma et al, 2002, and the Montana Strategic Suicide Prevention Plan Work Group)

- Male
- Age (the older the age, the greater the risk)
- Bereavement (loss of a loved one)
- Physical illness, uncontrollable pain or the fear of a prolonged illness;
- Perceived poor health
- Social isolation and loneliness
- Undiagnosed depression
- Neurobiological factors: age-related effects on central serotonergic function are associated with a predisposition to impulsive and aggressive acts along with greater risk of depression (Mann, JJ., 1998)
- Major changes in social roles (e.g. retirement, transition to assisted living)
- Contrary to popular opinion, only a fraction (2-4%) of suicide victims have been diagnosed with a terminal illness at the time of their death.
- Financial insecurity (Montana Strategic Suicide Prevention Plan Work Group)

Protective Factors

Some individuals and communities are more resistant to suicide than others. Little is known about these protective factors. However they might include genetic and neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. As with prevention and intervention activities, when programs to enhance protective factors are introduced, they must build on individual and community assets. They must also be culturally appropriate. As an example protective factors enhancement in any one of Montana's American Indian communities must capitalize on the native customs and spiritual beliefs of that nation, tribe or band.

According to the National Strategy of Suicide Prevention (2001), protective factors for all ages include:

- Effective and appropriate clinical care for mental, physical and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support
- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts, including American Indians practice of non-separation of culture, spirituality, and/or religion

When we explored the protective factors for specific age groups, we found some differences. The following are the protective factors identified for youth and the elderly:

Protective Factors for the Young

(The protective factors were taken from the Maine Youth Suicide Prevention Program (2006) created through the Maine Department of Health and Human Services.)

- Dominant attitudes, values, and norms prohibiting suicide, including strong beliefs about the meaning and value of life
- Life skills (i.e., decision-making, problem-solving, anger management, conflict management, and social skills)
- Good health, access to health care
- Best friends, supportive significant others
- Religious/spiritual beliefs
- A healthy fear of risky behavior, pain
- Hope for the future
- Sobriety
- Medical compliance
- Good impulse control
- Strong sense of self-worth
- A sense of personal control
- Strong interpersonal bonds, particularly with family members and other caring adults
- Opportunities to participate in and contribute to school and/or community projects/activities
- A reasonably safe, stable environment
- Difficult access to lethal means
- Responsibilities/duties to others
- Pets

Protective Factors for the Elderly

(taken from Luoma et al, 2002, and the Montana Strategic Suicide Prevention Plan Work Group, 2008)

- Female
- Established Social Support Network
- Positive health
- Social activity
- Cultural and religious beliefs
- Coping or problem-solving skills
- Genetic or neurobiological makeup
- Restricted access to lethal means
- Adequate access to healthcare for mental health and pain management
- Higher life satisfaction
- Experience and wisdom (Montana Strategic Suicide Prevention Plan Work Group)
- Pets (Montana Strategic Suicide Prevention Plan Work Group)

Later in the plan when the discussion focuses on other populations in Montana with a high risk of suicide, specific risk and protective factors for those populations will be identified.

Opportunities for Prevention Activities

The variations in suicide rates by age groups and gender provide a wide array of opportunities for prevention and intervention activities. Prevention strategies can cover a wide variety of target groups (e.g., population at large, those who have ever thought of suicide as an option, those who have made previous attempts at suicide, and those in immediate crisis who are contemplating suicide as well as those who have experienced the death of a family member or close friend). Such activities can also range from a broad focus such as addressing risk and protective factors to a more narrow focus such as preventing imminent self-harm or death. Although the data on effectiveness of various programs and interventions is limited, certain strategies are beginning to emerge as more effective than others. Clearly, a singularly focused intervention strategy such as a crisis line or gatekeeper training program will not have a lasting impact in isolation. Each program needs to be tightly integrated and interlinked with other strategies to reach the broadest possible range of persons at risk. Various prevention activities have been identified for young people, older adults, and senior Caucasian males.

Youth – Ages 10 - 24

Although males are more at risk of dying from suicide, females make more attempts. Among the leading causes of hospital admission for women in this age group are poison-related suicide attempts, however there has been a significant increase in suffocation/hanging in young females in the past four years.

Possible prevention measures for this group include:

- Implementation of the "Good Behavior Game" in 1st and 2nd grade. Studies have suggested that the skills taught in this game may delay or prevent onset of suicidal ideations and attempts in early adulthood (Wilcox et al., 2008).

- Implementation of evidenced-based school curriculums, such as Signs of Suicide (SOS), Teen Screen, or the American Indian Life Skills Development, into Montana schools.

- Implementation of evidenced-based practices in hospital emergency rooms such as the Emergency Department Means Restriction Education program or the Specialized Emergency Room Intervention for Suicidal Adolescent Females. These programs focus on educating parents about high risk youth and limiting access to lethal means for suicide.

- Increase in awareness and access to counseling services provided at state colleges and universities.

- Home visitation to high risk young families by Public Health personnel.

- Therapeutic Foster Care for high needs youth to provide a safe environment in which "wrap around" services could be provided.

- Inclusive, drug free, violence free, after school activity programs that run between 3pm – 8pm; offering a wide array of activities including the arts, volunteer opportunities and sports which will appeal to youths of varied backgrounds. These programs provide adult supervision by both qualified staff and volunteers and provide a forum for community resiliency and mentoring.

- School-based mentoring programs for at-risk youth as well as students transitioning to high school, provided by older students and/or adults .

- ASIST/QPR training for adults who work with youth to reduce stigma around suicide and raise awareness of risk factors and provide referral information.

- Increased firearm safety measures. Based on their research, Grossman and his colleagues made the following summary: "storing household guns as locked, unloaded, or separate from the ammunition is associated with significant reductions in the risk of unintentional and self-inflicted firearm injuries and deaths among adolescents and children. Programs and policies designed to reduce accessibility of guns to youth, by keeping households guns locked and unloaded, deserve further attention as one avenue toward the prevention of firearm injuries in this population" (Grossman, et al, 2005).

- Reducing illegal drugs (methamphetamine, marijuana, etc.), alcohol and lethal prescription drugs would decrease the impact of this risk factor for suicide.

- Continue development of youth areas on the DPHHS website. http://www.dphhs.mt.gov/PHSD/family-health/suicide-prevention/suicide-prev-index.shtml website based at DPHHS; youth are likely to go to websites before using a crisis telephone line.

- Enhance protective factors and provide coping skills for youth in all arenas of life.

- There is a correlation between smoking and suicidal behavior in people of all ages (see section later in report on suicide and smoking). *European Psychiatry* (2007) reported after adjusting for psychiatric diagnoses, an over twofold risk for suicide attempts was found among adolescents who smoked over 15 cigarettes a day. Additionally, if an adolescent also smoked the first cigarette immediately after waking up the risk was over threefold.

Older Adults – Ages 25 - 64

This group represents the biggest actual number of suicides in Montana; most suicides in this group are male and completed with use of a gun. Interventions for this group could include:

- Addressing the significant stigma associated with admitting to having depression or a mental illness. This could be achieved through a public awareness campaign addressing the myths and stereotypes associated with having a mental illness and beginning to challenge the culture of acceptance around suicide.

- Continued implementation of evidenced-based gatekeeping programs such as QPR and ASIST in communities to increase recognition of warning signs of suicide and to intervene with appropriate assistance.

- As the primary first responders, increase the number of law enforcement personnel and correctional officers around the state trained in Crisis Intervention Training (CIT).

- Having physicians receive gatekeeper training and subsequently assessing all patients for depression and suicide risk factors and making appropriate and timely referrals for mental health services.

- Due to the correlation between smoking and suicidal behavior (see section later in report on suicide and smoking), focus smoking cessation campaigns towards this age group.

- Crisis lines - recently, two large SAMHSA-funded studies found that telephone crisis services, like those in the Lifeline network, can provide an effective mental health and suicide prevention service for callers (Kalafat et al., 2007; Gould et al., 2007). A study of 1,085 suicidal and 1,617 non-suicidal crisis callers to 8 crisis lines found that callers showed significant reductions on all measures of emotional distress, hopelessness and suicidality by the end of the call, as well as at follow-up 2 to 3 weeks later.

- Development of lay provider crisis intervention teams, creating more hospital beds designated for mental health, and suicide stigma reduction campaigns would increase intervention possibilities for suicidal individuals.

- As in the younger group, increase in awareness and access to counseling services provided at state colleges and universities.

Senior Caucasian Males, Over Age 65

Rural isolation, lack of access to mental health resources and access to lethal means are major risk factors with this age group. Prevention efforts for this population should focus on:

- The development of calling trees set up among senior volunteer groups to reduce isolation.

- Providing gatekeeper interventions (ASIST, QPR) among caregivers and volunteer groups.

- The medical community serving this population could be trained in gatekeeper strategies and begin to universally screen patients for depression, mental illness and or drug/alcohol abuse.

- Senior suicide is related to severe illness and chronic pain. Improved pain management and increased resiliency among this group could reduce suicide.

- Exploration of implementing an evidenced-based intervention such as the Prevention of Suicide in Primary Elderly: Collaborative Trial (PROSPECT), into community programs.

This group has one of the highest rates of suicide in the United States and Montana:

- In 2005, 5,404 people over the age of 65 died by suicide for a rate of 14.69 per 100,000 people, compared to the national rate of 11.01 (CDC, 2008).

- In Montana in 2006, there were 39 suicides by people over the age of 65 for a rate of 25.66 per 100,000 people. Over the period between 2000 and 2006, the rate of suicide for Montanans over 65 is 24.68 per 100,000 (Montana Vital Statistics, 2008).

- Out of those 39 Montana suicides, 30 of them were completed by firearms.

Other Populations in Montana with a high risk of Suicide

Suicide Among American Indians

The following information was obtained from the Suicide Prevention Resource Center website entitled, "Suicide Among American Indians/Alaska Natives" (2007) and the CDC *WISQAR* (2008).

The Centers for Disease Control and Prevention report that, from 2000 to 2005:

- The suicide rate for American Indians/Alaska Natives in the United States was 10.82 per 100,000, compared to the overall US rate of 10.77. **However, the suicide rate in Montana for American Indians/Alaska Natives during that same time period was 21.47 per 100,000 people**.

- Nationally, adults aged 25-34 had the highest rate of suicide in the American Indian/Alaska Native population, 18.77 per 100,000. **However, in Montana, adults aged 35-44 had the highest rate of suicide in the American Indian/Alaska Native population, 46.65 per 100,000 people.**

- Suicide ranked as the eighth leading cause of death for American Indians/Alaska Natives of all ages.

Suicide ranked as the second leading cause of death for those from age of 10 to 34.

Youth Statistics

- Among American Indian/Alaska Native youth attending Bureau of Indian Affairs schools in 2001, 16% had attempted suicide in the 12 months preceding the Youth Risk Behavior Survey.

- From 1999 to 2004, American Indian/Alaska Native males in the 15 to 24 year old age group had the highest suicide rate, 27.99 per 100,000, compared to white (17.54 per 100,000), black (12.80 per 100,000), and Asian/Pacific Islander (8.96 per 100,000) males of the same age.

Youth Risk Factors
(Bender, E., 2003)

The risk factors correlated with suicidal behavior unique to reservation youth were:

- depression
- a family history of drug abuse
- alcohol abuse (in the youth)
- an arrest history
- racial discrimination

Many of the reservation youth were bused to schools in predominantly white suburbs. In focus groups, the youth living on the reservations reported a great deal of discrimination against them, perhaps most surprisingly by their teachers. The risk factor correlated with suicidal behavior unique to urban youth was less social support. Some of the risk factors correlated with suicidal behavior that urban and reservation youth shared were:

- exposure to suicidal behavior by a friend or family member,
- a history of physical and sexual abuse,
- having a diagnosis of conduct disorder or a substance use disorder.

Mental Health Considerations

- When compared with other racial and ethnic groups, American Indian/Alaska Native youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression.
- Mental health services are not easily accessible to American Indians and Alaska Natives, due to:
    - lack of funding,
    - culturally inappropriate services,
    - mental health professional shortages and high turnover.

For these reasons, American Indians tend to underutilize mental health services and discontinue therapy.

Ethnic and Cultural Considerations

- According to the U.S. Commission on Civil Rights, American Indians continue to experience higher rates of poverty, poor educational achievement, substandard housing, and disease.
- Elements of acculturation - mission and boarding schools, weakening parental influence, and dislocation from native lands - undermine tribal unity and have removed many safe guards against suicide that American Indian culture might ordinarily provide.
- There are very few evidence-based programs that are adapted for American Indian and Alaska Native cultures.

Strengths and Protective Factors

- The most significant protective factors against suicide attempts among American Indian/ Alaska Native youth are:
    - discussion of problems with family or friends,
    - connectedness to family,
    - emotional health.
- Culturally sensitive programs that strengthen family ties, including addressing substance abuse, could protect against suicide among Native American adolescents.
- A study of American Indians living on reservations found that tribal spiritual orientation was a strong protective factor. Individuals with a strong tribal spiritual orientation were half as likely to report a suicide attempt in their lifetimes (SPRC, 2007).
- School-based strategies: For American Indian and Alaska Native communities in particular, the lack of behavioral health access and geographic isolation can be addressed more effectively by forming integrated care models that center suicide prevention/intervention activities around the schools. School-based behavioral health care is a promising solution to these issues. Whenever possible, the best approach to school-based suicide prevention activities is teamwork that includes teachers, school health personnel, school psychologists and school social workers, working in close cooperation with behavioral health, community

agencies, and families. School-based strategies include:

- Suicide awareness curriculum (such as American Indian Life Skills Development, Native HOPE, SOS: Signs of Suicide, Yellow Ribbon)
- Staff and faculty training (gatekeeper training such as QPR or ASIST)
- Screening (Columbia Teen Screen)
- On-site prevention and behavioral health programs/ services
- Create a Crisis Intervention Team
- Postvention

Suicide among Montana's Veterans

Another special population in Montana that is at high risk of suicide is Montana's military veterans. Montana has more than 100,000 veterans, or nearly one person in every 10. Montana had the highest recruitment in the nation per capita into the U.S. Army in 2004 and 2005. Montana has approximately 648 Army National Guard Soldiers between the ages of 18 and 24 who have been deployed to date for both CONUS (Continental United States) and OCONUS (Outside the Continental United States) missions in support of OIF (Operation Iraqi Freedom) and OEF (Operation Enduring Freedom). This is not only a major concern in Montana but at a national level as well. According to data (CBS News, 2007) from 45 states, 6,256 men and women who had served in the armed forces took their own lives in 2005 - that's 120 suicides every week. The American Journal of Public Health (AJPH) examined suicide rates using data from the VA's National Registry for Depression for 807,694 veterans of all ages diagnosed with depression and treated at any Veterans Affairs facility between 1999 and 2004 (Zivin, et al, 2007). What they found was that in all, 1,683 veterans in VA

Suicide Signs Unique to Vets

Experts on suicide prevention say for veterans there are some particular signs to watch for.

- Calling old friends, particularly military friends, to say goodbye
- Cleaning a weapon that they may have as a souvenir
- Visits to graveyards
- Obsessed with news coverage of the war, the mili tary channel
- Wearing their uniform or part of their uniform, boots, etc
- Talking about how honorable it is to be a soldier
- Sleeping more (sometimes the decision to commit suicide brings a sense of peace of mind, and they sleep more to withdraw)
- Becoming overprotective of children
- Standing guard of the house, perhaps while every one is asleep staying up to "watch over" the house, obsessively locking doors, windows
- If they are on medication, stopping medication and/or hording medication
- Accumulating alcohol -- not necessarily hard alcohol, could be wine
- Spending spree, buying gifts for family members and friends "to remember by".
- Defensive speech "you wouldn't understand," etc.
- Stop making eye contact or speaking with others.

depression treatment died by suicide during the study observation period. This equates to an overall suicide rate in this population of over 88.3 per 100,000 persons, which is approximately 7-8 times greater than the suicide rate in the general adult US population. Military service comes with special challenges, and the 1999 Veterans Health Study found that nearly a third -- 31 percent -- of veterans were suffering depressive symptoms, a rate that's two to five times higher than observed in the general public.

Predictors of suicide among veterans in depression treatment differs in several ways from those observed in the general US population. Typically, people in the general population who die by suicide are older, male, and white, and have depression and medical or substance abuse issues. In the AJPH study, researchers found that depressed veterans who had substance abuse problems or a psychiatric hospitalization in the year prior to their index depression diagnosis had higher suicide rates.

However, when they divided depressed veterans into three age groups: 18 to 44 years, 45 to 64 years, and 65 years or older, they found that the younger veterans were at the highest risk for suicide. Differences in rates among depressed veterans of different age groups were striking;18-44 year-olds completing suicide at a rate of 95.0 suicides per 100,000, compared with 77.9 per 100,000 for the middle age group, and 90.1 per 100,000 for the oldest age group.

In this VA treatment population, male veterans were more likely to complete suicide than female veterans. Suicide rates were 89.5 per 100,000 for depressed veteran men and 28.9 per 100,000 for veteran women. However, the differential in rates between men and women (3:1) was smaller than has been observed in the general population (4:1).

Recent Legislation to Prevent Veteran Suicide

*On November 6, 2007, President Bush signed into law the **Joshua Omvig Veterans Suicide Prevention Act**. It's named after a soldier who committed suicide in Grundy County, Iowa, in December 2005, after serving an 11-month tour in Iraq. The bill requires the Department of Veteran's Affairs to meet deadlines in providing the following services:*

- Train VA staff on suicide prevention and mental health care
- Staff each VA medical facility with a suicide prevention counselor
- Screen soldiers who seek care through the VA for mental health needs
- Support outreach and education for veterans and their families
- Research the most effective strategies for suicide prevention
- Create a peer support counseling program so veterans can help other veterans

However, while the bill requires the VA to provide these services, it provides no new funding

Surprisingly, the initial findings revealed a lower suicide rate among depressed veterans who also had a diagnosis of post-traumatic stress disorder (PTSD) compared to depressed veterans without this disorder. Depressed veterans with a concurrent diagnosis of PTSD had a suicide rate of 68.2 per 100,000, compared to a rate of 90.7 per 100,000 for depressed veterans who did not also have a PTSD diagnosis. Concurrent PTSD was more closely associated with lower suicide rates among older veterans rather than among younger veterans.

This study did not reveal a reason for this lower suicide rate, but the hypothesis was that it may be due to the high level of attention paid to PTSD treatment in the VA system, and the greater likelihood that patients with both depression and PTSD will receive psychotherapy and more intensive visits. In general, individuals with depression and PTSD diagnoses have higher levels of VA mental health services use than individuals with depression without PTSD.

Suicide among those with Serious Mental Illness (SMI)

According to Mental Health America (Mark, et al., 2007), 12.46% of Montana's adult population has serious psychological distress and approximately 9% of Montana adolescents and adults have major depressive episodes. Individuals with serious mental illness (SMI) constitute 6-8% of the U.S. population, but account for several times that proportion of the 32,000 suicides that occur each year in the country (Litts et al. 2008). For people with virtually every category of SMI, suicide is a leading cause of death, with lifetime risks ranging from 4-8%. Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors. Still, a large majority of those with SMI neither attempt nor die by suicide and predicting those who will presents a significant challenge.

There are multiple risk factors, often acting together, that greatly influence the extent to which suicide attempts and completions occur. A highly common risk factor combination is a mood disorder co-occurring with a substance use disorder. This combination when associated with a host of additional risk factors or triggers, such as a major stressful event, binge use of substances, certain personality features (e.g., impulsivity), or a recent discharge from a hospital, greatly increase the risk of suicide. Some of the triggering factors may be generic to anyone with a psychiatric disorder, while others may be fairly unique to specific disorders.

The most common risk factors that apply across many psychiatric disorders include:

- prior suicide attempt
- intimate partner conflict
- social isolation
- family history of suicide, mental disorder or substance abuse
- family violence, including physical or sexual abuse
- firearms in the home
- legal charges or financial problems
- incarceration
- exposure to the suicidal behavior of others, such as family members, peers, or media figures
- physical illness and functional impairment, especially in older people

Additionally, there are several mental illness-related symptoms that act as acute risk factors. These include:

- severe hopelessness
- impulsivity
- unrest, instability
- agitation, panic, anxiety
- relational conflict
- aggression, violence
- alcohol/substance abuse
- insomnia

The following mental disorders present a high risk of suicide:

Mood Disorders

Across all psychiatric disorders, mood disorders, which include major depressive disorder and bipolar disorder, appear to carry the highest risk of suicide and suicide attempts. For patients ever hospitalized for a mood disorder, the lifetime risk is 4%, but for those ever hospitalized for suicidality, the lifetime risk is close to 9%. According to the Office of Applied Studies (2006), among adults aged 18 or older who experienced a major depressive episode in the past year, 56.3 % thought, during their worst or most recent episode, that it would be better if they were dead, 40.3 % thought about committing suicide, 14.5 % made a suicide plan, and 10.4 % made a suicide attempt. The survey also found that suicide attempts are far more likely in depressed adults who report binge alcohol or illicit drug use than by their counterparts who do not abuse substances. Suicide attempts were responsible for nearly 38,000 emergency room visits in 2004 by depressed adults using or abusing drugs. Later-life is a period of particular vulnerability in relation to mood disorders. A startling 74% of all attempts or completions among people older than age 55 were attributable to mood disorders (Beautrais, 2002). Prevention efforts should focus on assessment of suicidality on any patient experiencing a mood disorder by those in the medical and mental health professions.

Schizophrenia

According to Litts et al (2008), suicide is the leading cause of early mortality in people with schizophrenia. A person with schizophrenia has a lifetime risk of suicide of nearly 6%. The first ten years after diagnosis is a period of higher risk, suggesting that suicide prevention efforts should be focused on newly diagnosed people. An analysis of the suicide risk factors for people with schizophrenia found elevated risk was related less to the core psychotic symptoms of the disorder and more to the following (Hawton et al., 2005):

- affective symptoms (worthlessness, hopelessness, agitation or motor restlessness)
- awareness that the illness is affecting mental functioning
- living alone or not living with family
- recent loss events
- previous suicide attempts
- previous depressive disorders
- drug misuse
- fear of mental disintegration
- poor adherence to treatment

Anxiety Disorders

In the past, the risk of suicidal behavior from anxiety disorders was not seen as serious enough to warrant national attention. More recently, however, studies have found that any type of anxiety disorder has independent risk factors for suicide attempts. This suggests that anxiety does not have to be co-morbid with other disorders to be a suicidal risk. The onset of an anxiety disorder of any kind doubles the risk of suicide attempts. Some anxiety disorders, for example, simple phobia, are unlikely to meet the Federal definition of an SMI. But others, such as PTSD, frequently meet the criteria, yet research often aggregates them under the mantle of "anxiety disorders." That categorization tends to diminish the perception of their severity and the associated suicidal risk. The two anxiety disorders most frequently associated with suicide completion are panic disorder and PTSD. According to the National Center for Post Traumatic Stress Disorder (2007), there is a large body of research indicating a correlation between PTSD and suicide. There is evidence that traumatic events such as sexual abuse, combat trauma, rape, and domestic violence generally increase a person's suicide risk. Considerable debate exists, however, about the reason for this increase. Whereas some studies suggest that suicide risk is higher due to the symptoms of PTSD, others claim that suicide risk is higher in these individuals because of related psychiatric conditions. Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide. High levels of arousal symptoms and low levels of avoidance have also been shown to predict suicide risk. In contrast, other researchers have found that conditions that co-occur with PTSD, such as depression, may be more predictive of suicide. Furthermore, some cognitive styles of coping, such as using suppression to deal with stress, may be additionally predictive of suicide risk in individuals with PTSD. Given the high rate of PTSD in veterans, considerable research has examined the relation between PTSD and suicide in this population. Multiple factors contribute to suicide risk in veterans. Some of the most common factors are listed below:

- male gender
- alcohol abuse
- family history of suicide
- older age
- poor social-environmental support (exemplified by homelessness and unmarried status)
- possession of firearms
- the presence of medical and psychiatric conditions (including combat-related PTSD) associated with suicide

Currently there is debate about the exact influence of combat-related trauma on suicide risk. For those veterans who have PTSD as a result of combat trauma, however, it appears that the highest relative suicide risk is in veterans who were wounded multiple times or hospitalized for a wound. This suggests that the intensity of the combat trauma, and the number of times it occurred, may influence suicide risk in veterans with PTSD. Other research on veterans with combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt. Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war. These thoughts can often overpower the emotional coping capacities of veterans.

Substance Use Disorders

Substance Use Disorders such as alcohol intoxication, by itself, does not constitute a psychiatric disorder, much less an SMI, but its role in suicidal behavior is profound. Acting as a disinhibitor, alcohol is involved in up to 64% of suicide attempts or completions, many of them associated with the combination of impulsivity, anger, and relationship losses (Goldsmith et al., 2002). The findings from several autopsy studies reveal that 25% of all individuals who die by suicide are intoxicated at the time of death (Goldsmith et al., 2002). Alcoholism is associated with higher rates of suicide attempts, as well. One urban study showed those with alcoholism had five times the number of attempts as those with other psychiatric diagnoses. Comorbidity appears to play an important role in suicidal behaviors. Four million Americans have a substance use disorder plus an SMI. In fact, studies show that major depression existed at the time of death in 45 to >70% of suicides involving a history of alcoholism (Sher, 2005). Prevention efforts with this population would include a greater awareness of the signs of suicide and the correlation between substance abuse and suicide in chemical dependency treatment providers.

Increased Risk of Suicide among Suicide Survivors

The risk of suicide in survivors is an area in need of further research. According to the American Association of Suicidology (2007), there are six survivors for every completed suicide. Based on this figure, there are approximately 5 million survivors in the U.S. in the last 25 years or 1 out of every 65 Americans. Six new survivors are added to the cohort every 16.2 minutes. For survivors experiencing complicated grief associated with the death of a loved one by suicide the risk for suicidal ideation or attempts is elevated. According to Litts et al. (2008) stigmatizing reactions add to a survivor's burdens, often intensifying their social isolation and secrecy while impeding their access to accurate information that could help them recover, or in some cases, become involved as advocates for suicide prevention. Suicide survivors frequently report unique problems and challenges following the death of their loved one. These include:

- A prolonged and intense search for the reason for the suicide
- Feelings of being rejected by the deceased
- A distorted sense of responsibility for the death and the abil-

In Montana, the following support groups have been identified by AFSP. Others may be available and people are encouraged to contact their community mental health agency for information concerning other support groups.

Billings
Meeting Place: UCC Conference Office, 2016 Alderson Ave., Billings, MT 59102
406-322-8587
Meeting Day(s)/Meeting Time:
1st and 3rd Mondays of every month, 6:00 p.m
Facilitated by: Trained Survivor Facilitator
Leadership Type: Peer
Charge: No
Newsletter: No

Bozeman
Bozeman Deaconess Hospital
915 Highland Blvd
Bozeman, MT 59715
Group Name: Suicide Loss/Saving Lives
(406) 570-8353
Leadership Type: Peer
Meetings/Month: 1 - 1st Thursday, 7 PM
Charge: NO
Newsletter: NO

ity to have prevented the suicide

- Feelings of being blamed, by others or themselves, for causing the problems that led to the suicide
- Elevated levels of anger, family dysfunction, and feelings of social stigmatization.

Furthermore, survivors of a suicide have a high likelihood of not seeking out formal or informal support or mental health treatment. Those that seek these forms of help may be thwarted by difficulty locating resources or by their own overwhelming grief. Large numbers of adult survivors find that they improve their ability to cope with the many and complex facets of being a suicide survivor by participating in formal support groups with others who have experienced loss through suicide. Children who survive the suicide of a parent or guardian frequently struggle with guilt and feelings of abandonment. Adults who were traumatized as children by the suicidal behaviors of caretakers observe that using secrecy to protect the child-survivor may cause additional complications and misperceptions. Children need to know that the death was not their fault and that their continued care is certain. Honest, age-appropriate communication with the child is critical (AAS, 2007).

Intervention for this population should include increased awareness of the survivor's own suicidality and access to local support groups. To your right, the American Foundation for Suicide Prevention (www.afsp.org) identified the following survivor groups in Montana.

Columbus
Group Name & Mailing Address:
Stillwater Suicide Bereavement Support Group
Columbus, MT 59019
(406) 322-8587,
Survivor Facilitator is available for support group meetings
Facilitated by: Trained Survivor Facilitator
Leadership Type: Peer
Charge: No
Newsletter: No

Helena
Meeting Place: Suzanna's Place, Room 207
512 Logan Ave, Helena, MT
406-457-8906
Meeting Day(s)/Meeting Time:
First Tuesday of every month, 7:00-8:30 pm
Open group
Facilitated by: Trained Survivor Facilitators
Leadership Type: Peer
Charge: No
Newsletter: No

Kalispell
SOLAS (Surviving our loss after suicide)
The Summit Community Center for Health Promotion and Fitness
P.O. Box 2363
Kalispell, MT 59903
Group Name: SOLAS
(406) 212-6380
www.suicide-montana.org
Leadership Type: Peer
Meetings/Month: 1 - 1st Monday, 7 PM
Charge: NO
Newsletter: YES

Missoula
HOPE
A New Song Resource Center
821 So. Orange St.
Missoula, MT 59801
Group Name: H.O.P.E.
(406) 543-2890
www.anewsong.org/home.html
Leadership Type: Peer
Meetings/Month: group meets periodically throughout year
Charge: NO
Newsletter: YES

Other resources for survivors can be found at the Suicide Prevention Resource Center's library for survivors at http://library.sprc.org/browse.php?catid=11

Suicide in Prisons and Jails

According to the Bureau of Justice Statistics (August, 2005), in the United States, jail suicide rates declined steadily from 129 per 100,000 inmates in 1983 to 47 per 100,000 in 2002. In 1983 suicide accounted for the majority of jail deaths (56%), but by 2002, the most common cause of jail deaths was natural causes (including AIDS) (52%), well ahead of suicides (32%). Suicide rates in State prison fell from 34 per 100,000 in 1980 to 16 per 100,000 in 1990, and have since stabilized. While the suicide rate in state prisons exceeds that for the general population, it is the smaller facilities in which prisoners are at extremely high risk. According to the Suicide Prevention Resource Center (October, 2007), the suicide rate for local jails is about four times that of the nation as a whole while the suicide rate for smaller jails (100 beds and fewer) is about ten times that of the nation. The most common means of suicide by inmates is by hanging, which can result in death in five or six minutes. Severe brain damage from hanging can occur in as little as four minutes. Inmates have died after hanging themselves from clothing hooks, shower knobs, cell doors, sinks, ventilation grates, windows, and smoke detectors. According to the Montana Department of Vital Statistics (2008), local Coroners reported 18 suicides in Montana's State Prison, federal detention centers, or

Suicide Prevention in Montana's Correctional Facilities

Correctional facilities should have written policies and procedures for both preventing suicides and responding to attempts that may occur. All staff at the facilities should be trained on when and how to implement these plans. At a minimum, suicide prevention plans should include protocols for the following:

Assessing suicide risk and imminent suicide risk. While a formal intake suicide risk and mental health assessment is an essential part of this process, an inmate's risk status can change dramatically over time. Thus, staff need to be trained to recognize and respond to changes in an inmate's mental condition.

Effective communication about suicide risk. Knowledge about an inmate's risk status and history can be lost as he or she is transferred between units or facilities (or as shifts change). Formal procedures for communicating knowledge about suicide risk of particular inmates will help staff maintain and target their vigilance. Information that needs to "follow" the prisoner includes the following:

- suicide threats by the inmate
- behaviors that indicate he or she may be depressed
- a history of psychiatric care and medication
- whether the inmate is in protective custody.

Use of isolation cells. While is it often appropriate for prisoners to be placed in isolation cells, this placement can raise the risk of suicide. If an inmate thought to be at risk of suicide requires isolation, attention must be paid to appropriate observation of the inmate as well as ensuring that all isolation cells are suicide-resistant – that is, minimize the presence of items that could be used for self-harm, such as bed sheets and projections from walls or furniture that could be used as anchors for a hanging.

Training for staff, including training in recognizing and responding to suicide risk, and training in first aid (including CPR) as well as the need to begin procedures such as CPR immediately.

Availability of appropriate first aid safety equipment, including latex gloves, resuscitation breathing masks, defibrillators, and tools for opening jammed cell doors and cutting down a hanging inmate.

county jails between 2003 and 2007 (preliminary data for 2007). Hanging was the means in all 18 cases. Four of the suicides occurred in the Montana State Prison, 13 occurred in county jails or detention centers, and one occurred in a federal detention center.

Prisons and jails contain large numbers of people with the types of mental illnesses associated with elevated risk of suicide. According to the Bureau of Justice Statistics half of prison and jail inmates have mental health problems. Approximately three-quarters of inmates with mental health problems have a co-occurring substance abuse disorder. Substantial numbers of inmates have major depressive disorders (29.7% of those in local jails, 23.5% of those in state prisons, and 16% of those in Federal prisons). Another Bureau of Justice Statistics study found that about 10% of those incarcerated in Federal or state prisons or local jails had reported at least one overnight stay in a mental institution prior to their arrest. An American Psychiatric Association review (2000) of the research literature concluded that 20% of prison and jail inmates are in need of psychiatric care and 5% are "actively psychotic".

The following intervention guidelines were taken from the Suicide Prevention Resource Center document, "*What Corrections Professionals Can Do to Prevent Suicide"* published in October, 2007. The guidelines identify the most effective way to prevent suicides in correctional facilities involves recognizing and responding to the warning signs that an inmate may be at imminent risk of trying to harm him or herself. These warning signs include the following:

- **Verbal warnings.** People who are considering killing themselves often talk about their plans. Staff should pay attention to similar thoughts or statements expressed in letters, poems, or other writings that may come to their attention.

- **Depression.** Although most people suffering from clinical depression do not kill themselves, a significant proportion of people who die by suicide are clinically depressed.

- **Psychosis.** Any signs of psychosis, such as talking to oneself, claiming to hear voices, or suffering hallucinations, should also be taken as a sign that the prisoner may be at risk. Staff should be especially alert if prisoners have stopped taking anti-psychotic or anti-depressive medication.

- **Reaction to incarceration.** Many suicides in jails occur during the first 24 hours of detention. Many occur when an inmate is under the effect of alcohol or drugs. Young adults arrested for nonviolent offenses – such as alcohol or drugs - are often at elevated risk of suicide. They can be afraid of jail, embarrassed by their situation, and afraid of reaction of their family and friends to their arrest.

- **Current precipitating events.** In addition to arrest and detention, there are other events that can precipitate a suicide attempt, including receiving bad news from home, conflict with other inmates, legal setbacks, withdrawal from drugs, and the tension caused by court hearings or sentencing , or sexual coercion.

- **Recognizing and Responding to the Warning Signs** -Correctional personnel should not be afraid to ask an inmate if he or she has considered suicide or other self-destructive acts. Asking someone if he or she has thought about suicide will NOT increase the risk of suicide. Correctional staff may want to be very direct and simply ask the question *"Are you thinking about killing yourself?*" It is very possible that an honest answer will not be forthcoming, given the tension that can exist between inmates and correctional staff and the unwillingness of prisoners to "open up" about issues that they may consider to be signs of

weakness. Any suspicion that a prisoner may be actively at risk of suicide should be communicated to a mental health professional. Any suspicion that a prisoner may be in imminent danger should be reported. Reports of such suspicions by inmates' families or other inmates should also be taken seriously. Some prisoners use the threat of suicide (or a "feigned" suicide attempt) to manipulate the system and, for example, delay a court date or obtain a transfer to another unit or facility. It is extremely difficult to tell whether an inmate is feigning suicide risk. Thus, all suicide threats must be taken seriously.

Suicide and Sexual Orientation

Another population that presents a significant risk of suicide is gay and lesbian youth. According to the Centre for Suicide Prevention (2003), 42% of gay and lesbian youth studied had thoughts of suicide at some time. 25% had thoughts of suicide in the past year, and 48% said thoughts of suicide were related to their sexual orientation.

There is little research concerning how much of a factor this is in Montana, however nationally, studies have shown that youth with same-sex orientation are 2-3 times more likely than their same-sex peers to attempt suicide (Russel, S.T. & Joyner, K., 2001, Centre for Suicide Prevention, 2003). Approximately 15% of youth who reported suicide attempts also reported same-sex attraction or relationships. These youth also presented as higher risk for alcohol abuse and depression. In Montana, the number of gay and lesbian youth is difficult to determine. However, according to the U.S. Census, for all ages, there are approximately 1,200 same-sex couples in Montana, which ranks Montana 48th in the nation (U.S. Census Bureau, Census 2000). This number is considered to be significantly lower than the actual number, especially since this number does not include youth.

According to the Centre for Suicide Prevention (2003), there are risk factors and protective factors for gay and lesbian youth. The primary risk factors include:

- Previous suicide attempt
- Suicidal behavior among friends
- Mental illness (depression, anxiety)
- Substance abuse
- Family dysfunction (parental alcoholism, domestic violence, divorce)
- Identity conflict or identity confusion
- Interrupted social ties or lack personal support networks (including rejection by family)
- Social inequity (limited social and legal protection, hostile school or work environment, physical and verbal victimization, harassment and persecution)

The primary protective factors include:

- Having a strong support system (family, peers, school, mental health services)
- Ability to maintain sense of confidence and self-esteem

Suicide prevention and intervention efforts should consider the role that victimization plays in the everyday lives of all youths and its potential effects on suicidality. As identified above, among primary youth suicide risk factors, high levels of depression and alcohol abuse are reported by same-sex orientation. It has been suggested that for gay and lesbian youths who are concealing their sexual identities, alcohol may be used to numb the related anxiety and depression. Research and prevention efforts with this population should also focus on depression and substance abuse as precursors to suicidality (Russel, S.T. & Joyner, K., 2001).

Support of gay and lesbian youth in schools can be achieved through:

- Developing and enforcing school policy to support and protect gay and lesbian youth from verbal and physical harassment.
- Educating school staff on issues related to sexuality
- Providing appropriate referrals for gay and lesbian youth with mental health problems
- Developing support groups for gay and lesbian youth.

Suicide and Smoking

According to the Center for Disease Control (Sustaining State Programs for Tobacco Control: Data Highlights 2006), 20.4% (142,000) of Montana adults smoke and 22.9% (11,000) of Montana youth (grades 9-12) smoke. An average of 1,400 Montanans die each year from smoking-attributable causes and it is projected that another 18,000 youth will die from smoking. There have been a number of studies that indicate a correlation between smoking and increased risk of suicide. Hemenway, et al (1993) found a strong correlation between suicide and smoking in nurses. In their study, women who smoked 1 through 24 cigarettes per day had twice the likelihood of committing suicide as those who had never smoked. Women who smoked more than 25 cigarettes per day had four times the likelihood of suicide in the succeeding 2 years as those who had never smoked. In another study published in the American Journal of Public Health (Miller, M. et al., 2000), compared with never smokers, heavy smokers were at increased risk for suicide. The risk of suicide increased with the number of cigarettes smoked daily. Current smokers of 15 or more cigarettes per day had more than 4 times the risk of suicide compared with never smokers. The suicide risk among former smokers was intermediate between the risks among never and current smokers. Possible explanations for the smoking–suicide connection have been proposed and are identified on the following page.

According to the Miller study (2000), the rate of suicide increased with the number of cigarettes smoked daily (The number indicates the crude incidence per 100,000 people.)

Never Smoked	12 suicides per 100,000 people
Former Smoker	18
Current Smoker, 1-14 cigarettes a day	32
Current Smoker, >15 cigarettes a day	55

Interventions for the problem of smoking should model the prevention recommendations made by the Montana Tobacco Prevention Advisory Board in their 2004 publication of the Montana Tobacco Use Prevention Plan (http://tobaccofree.mt.gov/mttobaccousepreventionplan.pdf)

Four possible explanations for the smoking–suicide connection were proposed:

- depression is a common antecedent of suicide and a condition that leads to smoking as a form of self-medication;
- smoking alters brain chemistry, leading to depression, which increases the risk of suicide;
- smoking leads to malignant disease, such as cancer, which increases the risk of suicide; and
- smoking is associated with other characteristics that predispose individuals to suicide, such as low self-esteem (not because smoking physiologically exacerbates low self-esteem, but because in our culture they tend to occur together).

10 Leading Causes of Death, Montana
(2000-2005, All Races, Both Sexes)

Age Groups

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 106	Uninten-tional Injury 33	Uninten-tional Injury 34	Uninten-tional Injury 48	Uninten-tional Injury 468	Uninten-tional Injury 338	Uninten-tional Injury 405	Malignant Neoplasms 846	Malignant Neoplasms 1,782	Heart Disease 9,554	Heart Disease 11,586
2	SIDS 58	Congenital Anomalies 12	Malignant Neo-plasms 13	Suicide 14	Suicide 153	Suicide 177	Malignant Neoplasms 241	Heart Disease 614	Heart Disease 1,175	Malignant Neoplasms 8,416	Malignant Neoplasms 11,404
3	Short Gestation 38	Homicide 10	Congenital Anomalies 6	Malignant Neoplasms 6	Homicide 49	Malignant Neoplasms 55	Suicide 223	Uninten-tional Injury 405	Chronic Low. Respiratory Disease 285	Cerebro-vascular 3,088	Chronic Low. Respiratory Disease 3,422
4	Maternal Pregnancy Comp. 31	Heart Disease 6	Homicide 6	Congenital Anomalies 5	Malignant Neoplasms 37	Heart Disease 31	Heart Disease 185	Suicide 201	Uninten-tional Injury 276	Chronic Low. Respiratory Disease 3,059	Cerebro-vascular 3,382
5	Placenta Cord Membranes 23	Malignant Neoplasms 6	Influenza & Pneu-monia 2	Heart Disease 4	Heart Disease 8	Homicide 29	Liver Disease 84	Liver Disease 173	Diabetes Mellitus 178	Alzheimer's Disease 1,472	Uninten-tional Injury 3064
6	Uninten-tional Injury 17	Influenza & Pneumo-nia 3	Benign Neo-plasms 1	Homicide 4	Congenital Anomalies 5	Liver Disease 17	Diabetes Mellitus 34	Diabetes Mellitus 106	Cerebro-vascular 176	Influenza & Pneumo-nia 1,156	Alzheimer's Disease 1,483
7	Neonatal Hemor-rhage 14	Septicemia 2	Heart Disease 1	Influenza & Pneumonia 3	Diabetes Mellitus 5	Diabetes Mellitus 16	Homicide 33	Cerebro-vascular 78	Liver Disease 168	Diabetes Mellitus 1,107	Diabetes Mellitus 1,449
8	Circulatory System Disease 11	Five Tied 1	Perinatal Period 1	Diabetes Mellitus 2	Cerebro-vascular 3	Cerebro-vascular 8	Cerebro-vascular 27	Chronic Low. Respiratory Disease 61	Suicide 126	Uninten-tional Injury 1040	Influenza & Pneumo-nia 1,284
9	Intrauterine Hypoxia 10	Five Tied 1	Pneumoni-tis 1	Cerebro-vascular 1	Influenza & Pneumo-nia 3	Compli-cated Pregnancy 7	Influenza & Pneumo-nia 18	Viral Hepatitis 40	Influenza & Pneumo-nia 55	Nephritis 601	Suicide 1,078
10	Bacterial Sepsis 6	Five Tied 1		Perinatal Period 1	Septicemia 3	Congenital Anomalies 6	Septicemia 17	Influenza & Pneumo-nia 37	Septicemia 44	Parkinson's Disease 389	Nephritis

The Vision

We value human life. We encourage all people and organizations in Montana to deal openly, collaboratively, and with sensitivity for all cultures to minimize suicide. We are working to create an environment where everyone will have access to qualified resources for help when they are in need.

The Mission

There will be a sustained reduction in the incidence, prevalence and rate of suicide and non-lethal suicidal behavior in Montana.

The Goals and Measurable Objectives

Although Montana has had one of the highest rates of suicide in the nation for decades, it has only been in the last couple of years that an investment in preventing this public health issue has been made. In the past few years there has been legislation to address the issue of suicide along with significant efforts at the state, local, and tribal levels. However, change does not occur over night and with the issue of suicide, we are talking about changing a culture, and that takes time. Montana is also a large frontier state and many local efforts go unnoticed and collaboration is often difficult. For these reasons, one of our goals is to share what prevention activities are starting and ongoing at the state, local, and tribal levels. A compilation of current suicide prevention activities can be found in **Appendix A**.

To accomplish our mission and move towards the realization of our vision there are several key goals which we want to focus on in the next five years. Interventions to accomplish these goals and objectives can be found throughout this report, but specifically have been identified in the **Opportunities for Prevention Activities** section.

Reduce the incidence of completed suicide in Montana.

Measurable Objective: By 2013, Montana will be out of the national top 5 for rate of suicide as evidenced by final data for the *National Vital Statistics Reports*. This would equate to preventing at least 26 suicides in a given year in Montana (based on 2006 numbers).

Measurable Objective:By 2013, the Youth Risk Behavior Survey will demonstrate a 10% decrease in the number of youth reporting attempting suicide (compared to the 2007 survey).

Measurable Objective:By 2013, the Behavior Risk Surveillance System will demonstrate a 10% decrease in the number of adults reporting attempting suicide.

To systematically pursue promising and best practices related to prevention, intervention, and postvention strategies to implement statewide,

Measurable Objective:The State Suicide Task Force will meet on a quarterly basis to identify accomplishments, barriers, and collaborate on prevention efforts.

***To dedicate sufficient personnel and fiscal resources to address the issue of suicide prevention activities in a structured and long-term manner*,**

Measurable Objective:DPHHS will continue to allocate $400,000 a year toward supporting suicide prevention in the state.

Measurable Objective:DPHHS will identify and apply for future suicide prevention grants.

***To increase public awareness and concern around the issue of suicide as a leading cause of death and significant public health problem in Montana*.**

Measurable Objective:By 2009, implement a media campaign targeting 50% of Montana's population.

Measurable Objective:By 2009, educate all policy makers with research-based information about suicide in Montana.

Measurable Objective: By 2010, provide gatekeeper (QPR, ASIST) curriculum to 50% of Montana's American Indian population on reservations as measured by Planting Seeds of Hope.

Measurable Objective:By 2013, provide gatekeeper curriculum to 10% of Montana's population.

Measurable Objective:By 2013, provide crisis intervention training to 30% of all law enforcement and correctional officers.

***Increase evidenced-based suicide prevention curriculum being implemented in Montana's high schools*.**

Measurable Objective:By 2013, 40% of Montana's high schools (70 out of 175) will have an evidenced-based suicide prevention curriculum implemented.

Measurable Objective:By 2013, 50% of Montana's students will have been exposed to an evidenced-based suicide prevention curriculum in their high schools.

To work together in a collaborative, coordinated manner at the local, regional, tribal and state levels to best implement strategies and practices for suicide prevention.

Measurable Objective: The State Suicide Task Force will meet on a quarterly basis to identify accomplishments, barriers, and collaborate on prevention efforts.

To continually assess and evaluate progress towards our mission.

Measurable Objective:All State Suicide Task Force meetings will be open to the public and feedback from private and public stakeholders will be encouraged.

The Environment for Suicide Prevention in Montana

The State Strategic Suicide Prevention Work Group has identified factors that could impact the implementation of this plan. These factors include: assets that could have a positive and supportive impact on the implementation of the plan; barriers and challenges to carrying out the plan; and finally, near term opportunities that could be leveraged to aid in the successful implementation of the plan.

Attitudes

- To date there has been a lack of community awareness and acceptance of the problem.
- The debate continues in some groups about whether suicide is an individual or community problem. It is, for some, easier to tackle the "individual" problem (acute care or after the fact intervention) and more difficult to take on the "community problem" (primary prevention and encouraging protective factors).
- There is a lack of cultural awareness and sensitivity by suicide prevention staff and in prevention materials and programs.
- In many communities, there is insufficient expertise and capacity and often they must rely on expertise from outside of the local community to guide plans and activities. This lack of local capacity may result in the purchase of commercial products and programs that are without proven efficacy.
- The actual number of suicides within a given community is low; therefore, the problem is easy to ignore or dismiss.
- Sustaining interest in suicide prevention activities is difficult after a crisis situation or a completed suicide fades into the distant past.
- Changes in leadership often mean changes in public health agendas and priorities.

Montana's Unique Characteristics

- Much of Montana epitomizes geographical isolation, accentuated by the harsh winter climate.
- Since the arrival of the earliest white settlers, there has been an ingrained social culture that has accepted suicide as a part of life in Montana.
- Montana's rate of suicide has proven resistant to improvement from previous prevention efforts.
- There is a lack of availability and access to mental health services in many areas in the state, in part due to the state's remoteness.
- There is a prevalent and proud "western" culture and attitude among the Caucasian majority in Montana - 'we can take care of ourselves.'
- Frequently, there is access to firearms that are not properly stored.
- There is a lack of transportation services for some people that inhibits their ability to seek or receive help.
- There is a lack of communication infrastructure (phones, cellular service, and Internet access) in some areas, including American Indian reservations, frontier and rural areas.
- Montana ranks high in alcohol and substance abuse when compared to other states in the U.S.

Strategic Directions Toward Reducing Suicide in Montana

Due to the diversity of the State, the work group considers the most important direction to focus resources and attentions is promoting and working towards implementation of programs specific to communities and/or statewide. These programs are to be evidenced-based whenever possible and begin the process of changing the culture for future generations.

Prevention

- Address the stigma associated with mental illness and asking for help
- Increase awareness of youth suicide prevention and focus on social/ coping skill development
- Develop community provider networks
- Increase training for law enforcement agencies and hospital personnel
- Conduct gatekeeper (QPR, ASIST) trainings
- Provide screening programs (Teen Screen)
- Implement evidenced-based curriculum into Montana's schools (SOS).

Intervention

- Increase access to mental health and substance abuse services including smoking cessation programs.
- Develop and implement clinical screening programs and standard screening tools with appropriate referral and follow-up.
- Develop a statewide crisis response system.

Postvention

- Reduce access to lethal means with affected circles of suicide survivors
- Improve services for survivors
- Provide support and resources to families of persons at high risk or who have attempted
- Improve media reporting of suicides based on nationally recognized standards.

Coordination

- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults.
- Demonstrate collaboration

Assuring Support for the Plan

Key personnel, organizations and stakeholders were contacted for their review and comment throughout the process. The work group was encouraged to have their organizations and constituents review and comment on the plan after it was posted on the web site (http://www.dphhs.mt.gov/amdd/).

The Montana State Strategic Suicide Prevention Plan was presented to the Montana Public Health Association (MPHA) to keep them apprised of the ongoing efforts to reduce suicide in Montana.

After the final review and approval of the plan by the work group, the suicide prevention plan was reviewed and approved by the Montana Department of Public Health and Human Services.

Ongoing presentations of this Suicide Prevention Plan shall take place for mental health providers, advocacy agencies, and other individuals/agencies with concern about Montana's high suicide rates.

Progress Review and Plan Updates

As a way to assess and evaluate progress towards the goals, the Steering Committee will conduct a quarterly plan review and progress update on the plan. These reviews will include data from the various programs activities and practices suggested in the plan implementation strategy and exploration of funding opportunities.

Ongoing Activities

The reader is invited to visit http://www.dphhs.mt.gov/amdd/ to review ongoing activities, identify resources and explore links to prominent state and national organizations dedicated to addressing the many faces of suicide prevention.

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Appendix A

Current Suicide Prevention Activities Going On At the State, Local, and Tribal Level

Current Suicide Prevention Activities Going On At the State, Local, and Tribal Level

Montana continues to make progress in suicide prevention efforts. A great deal of progress has been achieved in suicide prevention training, increased knowledge and awareness about the problem of suicide and mental illness, expansion of provider networks and systems of care. There was also major legislation passed to address the issue of suicide in the state with Senate Bill 478. This bill allowed for the creation of the position of Suicide Prevention Coordinator. The bill also calls for additional support for the state suicide hotline, development of a biennial suicide reduction plan, revision of the state suicide prevention plan, coordinating current suicide prevention efforts around the state, increasing public awareness and training in suicide prevention, initiating a partnership with Montana's tribes and tribal organizations, and providing grants to communities for new programs and to sustain current programs.

In an effort to share ideas and encourage collaboration, it is important to identify what resources are available around the state and what prevention activities are being done in local communities. The following accomplishments have occurred in the state to address the problem of suicide:

1. The 24/7 Montana Suicide Prevention Crisis Line was stabilized and received additional resources. The suicide hotline utilizes the National Suicide Prevention Lifeline (1-800-273-TALK) as the primary suicide hotline number. The services are free and confidential. Once a person calls this number, they are routed to the nearest crisis center in the state. The state is now separated into two regions. Depending on the origin of the call, the call is routed to either Voices of Hope (Great Falls) or the Help Center (Bozeman).

2. The Curry Health Center at the University of Montana in Missoula has initiated a number of prevention programs on campus:

    - A "First Responder" booklet was developed for faculty and staff to know how to safely handle a student in crisis.

    - Suicide Warning Signs cards were creating identifying warning signs for mental health issues, the national suicide hotline number and the CAPS hours and contact information.

    - A Gatekeeper Program was introduced in spring, 2008 and focused on teaching select students, advisors, leaders, faculty and staff to act as a resource and "safe place" for students struggling with mental health issues or suicidal thoughts.

    - A Blues Fest program was started in 2007 incorporating blues music live performances around campus as a stage for discussions about depression.

    - 1100 flags were placed on the UM Oval to represent the number of students who take their own lives on college campuses every year.

    - The PROs student group created small "goodie bags" that included information on mental health as well as fun toys and other means for de-stressing (including bubbles, which were put to great use).

3. The University of Montana's Division of Educational Research and Service is coordinating youth suicide prevention projects at Rocky Boy and Fort Peck. Among the prevention efforts they have been implementing include:

   - Providing ASIST trainings.
   - QPR training to school staff and community members
   - Bully prevention training to school staff
   - Implementing the American Indian Life Skills curriculum in schools
   - Maintaining local suicide prevention coalitions.

4. Cascade County is providing the following suicide prevention programs:

   - Teen Screen in all high schools in Cascade County.
   - Depression Screening in higher education units: MSU College of Technology (COT), University of Great Falls (UGF)
   - Depression Screening at Cascade City County Health Department monthly
   - Case Management for all positive screens from Teen Screen, COT, UGF
   - Case Management for all counselor referrals from local high schools, Shodair for youth returning to Cascade County, ER referrals for attempts and for high risk pregnancy program.
   - QPR to youth and community agencies
   - Post Survivor Website Conference
   - Cascade County Suicide Prevention Task Force meets quarterly

5. Lewis and Clark County is providing the following suicide prevention programs:

   - QPR training in the community
   - Teen Screen is being used in Capital High School and Helena High School
   - Started a Suicide Survivor's Group in the community.

6. DPHHS funded ASIST training (Applied Suicide Interventions Skills Training) to home health care personnel in four Montana communities (Butte, Miles City, Great Falls, Billings)

7. The Yellowstone City-County Health Department has been engaged in the following activities for suicide prevention and education:

   - QPR training to school staff and community members
   - Maintaining a local suicide prevention coalition with community representation from the Yellowstone Boys and Girls Ranch, NAMI, DPHHS-AMDD, County Schools, AFSP, local survivors and concerned citizens.
   - Hosted an Out of the Darkness Walk and raised $8,000.00 for the Montana AFSP chapter
   - Created and distributed 250 Survivor's of Suicide packets containing information for families and friends who have lost someone they love to suicide. These have been given to local funeral homes, first responders, and emergency room staff in Yellowstone County.
   - The Yellow Ribbon Presentation was brought in and gave presentations to 5 county high schools.

8. The Western Montana Mental Health Center is coordinating youth suicide prevention projects in Ravalli County via the Ravalli County Youth Suicide Prevention Alliance. In addition to developing that alliance of concerned individuals, suicide prevention efforts to date include:

   - Providing QPR training to school and local agency staff and community members
   - Implementing Teen Screen wellness screening in local schools
   - Working with local mental and behavioral health providers to develop a resource referral and support system
   - Collaborating with local school systems to develop and implement consistent pre and postvention protocols throughout the valley.
   - Sponsoring a regional 2 day conference on bullying.
   - Assisting in support and development of local suicide survivor support group.
   - Partnering with survivor groups to develop resource packets for families/other impacted by suicide.
   - Publishing a brochure noting suicide facts, warning signs, appropriate crisis response, and local resources.

9. The following suicide prevention activities have been occurring with the Confederated Salish & Kootenai Tribes of the Flathead Nation;

   In 2007:

   - ASIST 2-day workshops
   - QPR trainings
   - Suicide Prevention Awareness – All school District PIR day
   - Suicide Survivor Support Group Facilitators Training, Rapid City, South Dakota
   - Newspaper articles: 2007 (Recognizing Warning Signs, Who to Call, A Closer Look at Depression Feature Stories, What is ASIST)
   - Flyers circulated regarding ASIST workshops and Emergency Hotlines and Resources
   - Radio stations: ongoing promotion and public service announcements

   In 2008:

   - SuicideTALK 4 hour presentation
   - Support groups for women, men and vets (in development)
   - Ongoing ASIST workshops
   - Ongoing radio and television campaigns
   - SKC student and her daughter (appearing with Roxana and Larry Pitts on Good Medicine to share a story about depression, addiction, grief, loss, faith, hope, education and rediscovering life 2/21/08)

10. The Montana National Guard formed a Post Deployment Health Reassessment (PDHRA) Task Force in April 2006 to evaluate and confirm the adequacy of our redeployment processes. The following is a summary of the accomplishments of the PDHRA campaign plan:

    - **Modified Discharge Process -** The purpose is to confirm that and OIF/OEF discharge request is not related to a PTSD or other combat issue.
    - **Developed Crisis Response Team -** Two Crisis Response Teams were created. One team is located in Helena and the other in Great Falls.
    - **Modified PDHRA Process -** The current PDHRA process, conducted within 90-180 days after redeployment, has been extended out to 2 years.
    - **Mandated Enrollment into VA System -** All returning Soldiers and Airmen are now required to complete the VA Form 1010 EZ to enroll for VA benefits. This will expedite follow-on care through the VA if it becomes necessary.
    - **Suicide Prevention and PTSD/mTBI Training -** Increased training has been conducted on suicide prevention, PTSD, and mTBI.

- **Reaffirmed Drill Attendance Policy -** A policy letter was published to reaffirm a Soldier's (ARNG only) ability to drill immediately upon redeployment for the first 90-days (currently identified as a "no drill" period.)

- **Hired a PDHRA Program Manager -** A full time ASDO PDHRA Program Manager was hired.

- **Redesigned MTNG Website – Yellow Ribbon -** The Montana National Guard website located at www.montanaguard.com was updated to include information on the Beyond the Yellow Ribbon program.

- **Implemented Periodic Health Assessment -** This new program replaces the former Annual Medical Certificate and 5-year physical program with an annual medical review.

- **Redesigned Individual Mobilization Process -** Soldiers who volunteer to mobilize now receive the same redeployment information as units who redeploy.

- **Honorable Discharge Policy -** Published a policy memorandum to allow Guardsmen to request an honorable discharge based on deployment related PTSD or mTBI difficulties.

- **Expanded Family Resource Centers -** Additional funding resources have allowed the National Guard Family Program to hire two contracted part time Family Assistant Coordinators.

- **Increased Family Communications -** The Family Program has expanded their efforts to provide information and additional focus on PTSD/mTBI signs and symptoms along with resource information for families.

- **State Veteran's Affairs - MT Mental Health Assn -** The State Department of Veteran's Affairs has partnered with the Montana Mental Health Association to air a variety of state-wide Public Service Announcement radio spots.

- **Received Additional PDHRA Cycle from OSD -** Senator Baucus and Senator Tester met with Dr. Chu, Undersecretary of Defense for Personnel and Readiness, DoD, and secured an additional PDHRA cycle for Montana.

- **ITO's for Family Members -** National Guard Bureau extended funding to the Montana National Guard to place family members on orders to attend Deployment Cycle Support (DCS) events.

11. The **Missoula County Suicide Prevention Network** has been involved in a number of projects in their community. Some of the projects of the local suicide prevention network thus far have included:

    - QPR training of such citizen groups as teachers, first responders, hospital workers and others, regular listserv updates of as many as 350 people.

    - Presentations about suicide prevention have been made to groups as diverse as the League of Women Voters, the Bar Association, the Gay and Lesbian Community Center, and the County Commissioners.

- A billboard advertising the national hotline.
- Debriefing services for two schools after suicide deaths.
- New memorial policies and a new crisis response manual for the local school district
- A project to address accidental overdoses and appropriate disposal of pain medications, and gun lock giveaways.
- In 2008 one of the local hospitals opened an outpatient mental health clinic which will provide therapy, medications, and case management.
- Exhibited a billboard on a busy thoroughfare.
- An annual spring suicide prevention summit and fall Suicide Prevention and Awareness Week which includes a full week of educational programs, a memorial walk, and National Mental Health Screening Day participation.
- High schools teach suicide prevention in the health curriculum.
- A one-credit graduate seminar in suicide prevention is now offered in the Social Work department at the University of Montana.

12. The suicide prevention crisis number appeared on the inside cover of all March, 2008 Montana Dex phone books.
13. Television shows were done in March on the Big Sky channel and Helena Civic Television concerning suicide prevention in the elderly.
14. The Youth Services Division of the Department of Corrections includes Community Transition Centers, Juvenile Parole, Pine Hills Youth Correctional Facility, Riverside Youth Correctional Facility, Fiscal Specialists, Juvenile Interstate Compact and Juvenile Detention Licensing. In recent years, Youth Services has taken several measures to increase suicide awareness and prevention at their correctional facilities at Pine Hills and Riverside. Prior to arrival at either facility, all youth are required to be accompanied by a medical examination, social history, school records, as well as available psychological reports. Upon admission at both facilities, a wide variety of testing is administered.

    Should background material or intake testing indicate a serious mental disorder, the youth is referred to either the contracted psychiatrist or psychologist to be evaluated for possible placement in a residential treatment facility.

    In regards to training, all new staff receive 40 hours orientation along with 120 hours additional training the first year which includes but is not limited to CPR/Medic First Aid; Prison Rape Elimination Act; Suicide Prevention/Intervention; and Abuse Reporting. Staff members also receive training on gender responsive related issues. Staff also receive suicide prevention training plus training on the Trauma Symptom Checklist for Children along with training on mental health approaches and cultural sensitivity.

    In relationship to Pine Hills, the new facility was opened in 2000. There are cameras and audio monitoring systems throughout the facility, including some rooms. All rooms are single rooms. All showers, rooms, etc. were designed with suicide prevention in mind, i.e. high ceilings, rounded corners, collapsible hooks, etc.

15. In June of 2008, the Montana Department of Public Health and Human Services began to air a public service announcement on all local televisions stations and a number of radio stations statewide concerning suicide prevention and identifying the statewide suicide prevention crisis line number.

16. The Montana Department of Public Health and Human Services, in collaboration with the Montana Department of Corrections, provided funding for Crisis Intervention Trainings for Montana's law enforcement officers, beginning in June of 2008 and continuing.

17. The following suicide prevention activities have occurred in the Flathead Valley.

    - The Flathead Suicide Prevention Coalition was formed in December of 2006.
    - Over 580 youth and adults were trained in QPR and recognizing the signs of suicide and depression. Flathead Sheriff, Kalispell Police and Columbia Falls Police have also been trained in QPR.
    - The coalition worked with Hunter Safety instructors concerning training and safety issues. They collaborated with local shops selling fire arms about providing gun locks.
    - The coalition developed a letter for coroners to handout to bereaved family or friends, linking survivors with national and local resources.
    - The County Commissioners signed a proclamation in support of National Suicide Prevention Week and the efforts of the coalition.
    - The coalition has also been active in raising awareness about underage drinking in the Flathead Valley through outreach at health fairs, participation in Kevin's Last Walk, an alcohol awareness program.
    - The coalition has also received a grant from the National Network of Libraries of Medicine, Assessment and Planning, which has assisted with the implementation of suicide prevention education in the schools through the training, "Breaking The Silence".
    - The coalition continues to collaborate with SOLAS to facilitate monthly suicide survivor support groups.
    - The coalition links survivors with Ellen Kaminski, MSW, of Grace Hospice, who facilitates the bereavement group twice a month.

    Future events scheduled for later in 2008 include:

    - A "Breaking the Silence" training scheduled on April 18, 2008.
    - Involvement with National Suicide Prevention Awareness Week on September 15-19, 2008
    - Sponsoring the American Foundation for Suicide Prevention 10th Annual National Survivors of Suicide Day on November 22, 2008.
    - More QPR Trainings
    - Church Outreach, New Covenant Fellowship

- My Space awareness campaign through collaboration with Flathead County Youth Librarian Council.

- Working with local pediatricians to utilize a depression screen with youth ages 9-18 at wellness checks and annual sports physicals.

18. The Following Suicide Prevention Activities have been occurring with District II Alcohol & Drug Program's Suicide Prevention Project which includes the 5 Eastern Montana Counties of Dawson, Wibaux, McCone, Sheridan and Richland:

    - Conducted 28 QPR Trainings in 5 County Region/Trained 663 individuals

    - Established system with area hospitals to provide data for suicide attempts/completions for evaluation purposes, trained all hospital staff in QPR.

    - Conducted ASIST Trainings in Glendive & Sidney/trained 90 individuals during Suicide

    - Developed multiple press releases for region on statistics, Lifeline/local resources.

    - Developed informational brochures for all 5 counties specific to counties resources/sign and symptoms/and crisis lines.

    - Developed 5 Public Service Announcements throughout region on awareness and local resources available, ongoing.

    - Met with County's Child Protection Teams to review suicide prevention/intervention/ postvention policies in all 5 counties, strengthened networks, and increased awareness of resources.

    - Trained all CPT Teams in region in QPR, strengthened resource networks.

    - Met with School Administration in all 5 counties to review suicide postvention resources and policies/provided suicide prevention/intervention/postvention policy template for strengthening existing policies. Trained all school staff in QPR in region.

    - Provide all schools in region with suicide resources/local crisis line/LifeLine Information.

    - Trained Stephen Ministry in QPR to provide outreach to congregations in area.

    - Developed Suicide Prevention Posters with Life Line information/dispersed in 5-county region.

    - Developed youth led media campaign with Key Club Project Life Chapter.

    - Area newspapers began reprinting LifeLine Information for free.

    - Developed regions Public Service Announcements on 1-800-273-TALK

    - Participated health fairs in region to educate on Lifeline/ local resources/signs and symptoms.

    - Coordinating additional regional ASIST training.

19. On April 8, 2008, Broadwater High School in Townsend was the first school to implement the Signs of Suicide (SOS) curriculum. SOS was presented to over 200 high school students. Between April and September, 2008, 27 schools agreed to implement the SOS curriculum in the Fall of 2008.

20. The following suicide prevention services are available in the Bozeman area:

- Montana Mental Health Association- the mission is educating and advocating for the mental health of children and adults in Montana. Contact information: P.O. Box 88, Bozeman, MT 59771, 406-587-7774, www.montanamentalhealth.org. Contact person is Jana Lehman, jana@montanamentalhealth.org.

- Bozeman Help Center, open 8-8pm for walk-in counseling at 421 Peach Street and 24/7 at 586-3333. Staffed 24 hours by paid and volunteers trained people. Now connected to the National Suicide Prevention Lifeline (1-800-273-TALK).

- Ken Mottram at the Bozeman Deaconess Hospital, Spiritual Care Director who provides suicide survivor support group on the first Thursday of the month at 7pm at the hospital chapel; 915 Highland Blvd., 406-585-5073.

- Critical Illness and Trauma Foundation, 2075 Charlotte St. Suite 1, Bozeman, MT 59718 phone, 406-585-2659, www.citmt.org/index2.htm. This group provides education and EMT training to rural areas across the entire nation, not just Montana. The one aspect that is relative to suicide is the training offered to law enforcement and stakeholders in suicide prevention. This is done as a group and CIT is contracted by the organization.

- Bozeman Senior High Crisis Team contact person Shawna Rader, 522-6682

- Chief Joseph Junior High Crisis Team contact person Rosa Lee, 522-6320. This group of counselors and teachers respond to suicide crisis involving the schools.

- Grace Bible Church offers Griefshare to anyone who has had a loved one die including suicide, Cindy Covin contact person, 388-7627. http://www.griefshare.org

21. DPHHS supported a collaboration project with five county health departments (Gallatin, Lewis & Clark, Yellowstone, Missoula, Cascade) and Planting Seeds of Hope on improving gun safety in their communities.

22. DPHHS provided scholarships for 20 Native American youth to attend the Montana Urban Indian Health Suicide Prevention Workshop sponsored by the Indian Development & Educational Alliance, Inc.

23. Below is a summary of our Planting Seeds of Hope Suicide (PSOH) Prevention Project through the Montana-Wyoming Tribal Leaders Council:

<u>Planting Seeds of Hope Central Office</u> (Billings)

- State of Montana (DPHHS) Collaborations
    - ♦ Shared Costs on first ASIST training
- State of Wyoming Collaborations

- ♦ Shared Costs on ASIST trainings

- Developed 1-800-273-TALK Posters with the Lifeline office
- Developed 1-800-273-TALK stress basketballs, footballs, and megaphones promoting "Honor Your Life!"
- ASIST and QPR trainings conducted
- Speakers Bureau developing to promote youth
- Youth council developing at the reservations
- Developed an outstanding Advisory Board
- Promoting VISTAs for youth development on each reservation
- Reservation Hero component developing
- Posters promoting "Honor Your Life!" "Honor Your Ancestors!"
- Collaborations with BIA, Native Hope, Native Youth Council, IHS, Native Aspirations

<u>Blackfeet PSOH</u>

- Updated Suicide Prevention Plan
- Signed tribal council proclamation –
- Grief Support group implementation
- Suicide Prevention Infrastructure development within the community
- ASIST and QPR trainings conducted
- Suicide Prevention Tribal Work Group developed
- Consistent Youth presentations on Suicide Prevention
- Development of community groups for adults and youth
- Linkage with Native Hope program and I.H.S. for reservation youth
- Developed a Community Resource Guide
- Direct relationship developed with Voices of Hope
- Dissemination of Lifeline 1-800-273-Talk promotional material

<u>Blackfeet Community College</u>

- Implementation of American Indian Life Skills curriculum through local master trainer agreement

- Implementation of a 2-day training for student credit

Crow PSOH

- Updated Suicide Prevention Plan
- Suicide Prevention Infrastructure development within the community
- Signed tribal council proclamation –
- Consistent Youth presentations on Suicide Prevention
- "Honor Your Life" presentations at Little Bighorn College
- ASIST and QPR trainings conducted
- Suicide Prevention Tribal Work Group developed
- Strengthening of the Crow Health Organizations that include the Tribal Council as the managers.
- Linkage with Native Hope program and IHS for reservation youth
- Dissemination of Lifeline 1-800-273-Talk promotional material

Fort Belknap (Gros Ventre & Assiniboine Tribes)

- ASIST training conducted
- Suicide Prevention Infrastructure development within the community
- Linkage with Native Hope program and IHS for reservation youth
- Inclusion of two youth on our PSOH Advisory Council
- Scheduled ASIST training in community
- Will be utilizing VISTAs for youth development
- Suicide Prevention Tribal Work Group
- Linkage developed with Traditional Games Society promoting Tribal Health through past Tribal games
- Direct relationship developed with Voices of Hope
- Dissemination of Lifeline 1-800-273-Talk promotional material

Fort Belknap Community College

- Implementation of the American Indian Life Skills Development curriculum through existing courses dealing with suicide/suicide prevention

Fort Peck (Assiniboine & Sioux Tribes)

- ASIST trainings conducted
- American Indian Life Skills Development Curriculum implemented in community
- Monthly in-service suicide prevention trainings with assigned community organizations
- Suicide Prevention Work Group
- Grief Support Group implemented
- Linkage developed with Traditional Games Society promoting Tribal Health through past Tribal games
- Parenting Class developed and implemented
- Developed a Community Resource Guide/Kit
- Consistent School presentations on Suicide Prevention
- Direct relationship developed with Voices of Hope
- Volunteer status form developed to work together with IHS

Northern Cheyenne

- Developed a Community Resource Guide and updated Suicide Prevention Plan
- ASIST and QPR trainings conducted
- Dissemination of Lifeline 1-800-273-Talk promotional material
- Linkage with Native Hope program and IHS for reservation youth
- Community in-service training on suicide prevention to targeted organizations

Stone Child College (Rocky Boys Chippewa Cree)

- Implementation of American Indian Life Skills Development Curriculum through existing curricula

Salish Kootenai College

- Implementation of American Indian Life Skills Development Curriculum through existing curricula
- ASIST and QPR trainings conducted
- Suicide Prevention Task Force Group developed

Mental Illness is Treatable

Suicide is Preventable

If you are in crisis and want help,

Call the Montana Suicide

Prevention Lifeline at

1-800-273 TALK (8255)